



## ERGONOMIC/CUMULATIVE TRAUMA QUESTIONNAIRE

NAME \_\_\_\_\_ DEPT \_\_\_\_\_

DATE SORENESS WAS FIRST NOTICED \_\_\_\_\_ DATE OF ACCIDENT \_\_\_\_\_

1. Did the pain develop gradually or did you feel it all of a sudden?
2. Is this a problem that comes and goes?

### **SUDDEN**

3. What were you doing when the pain was felt?
4. Have you done this before? How often?
5. When you felt pain, were you doing it the way you usually do it? If not, what was different?
6. Did anything unusual or unexpected happen? Explain?
7. If not, how do you think the pain was caused?

### **GRADUAL**

8. When did you first notice pain coming on?
9. What had you been doing that you feel caused this pain to develop?
10. How long or how many times did you do this?
11. Have you ever done this before? How often?

12. Were you doing it the usual way you do it? If not, what was different?
13. Except for the pain that developed, do you remember anything unusual or unexpected that happened?
14. If not, what do you think has caused this pain?

**RECURRENT**

15. What kind of activity seems to bring on the pain?
16. How often does this problem occur?
17. Have you discussed this problem with your doctor?
18. Do you have any suggestions on how the company can help you avoid problems of this kind in the future? Please explain.

**COMMENTS:** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**SIGNATURES**

Interviewer: \_\_\_\_\_ Date: \_\_\_\_\_

Employee: \_\_\_\_\_ Date: \_\_\_\_\_

**Forward this supplement and a copy of the Supervisors Incident Investigation Report to the local Program Coordinator.**