Loss Control Services

QBE

Employee Symptom Survey

Reference

Name | Date

Job title | Department | Supervisor

Length of time at current job | Hours worked per week | Shift

Age | Height | Weight

Number of days away from work due to illness/injury in past 12 months

Mark all boxes that apply

☐ Right handed ☐ Male

☐ Left handed ☐ Female

Job description

Describe what you do at your job.

As a result of doing this job, do you routinely experience discomfort or pain, (day or night) in any of the following areas? Please check all that apply.

Fingers	☐ No	☐ Left	☐ Right
Hand	☐ No	☐ Left	☐ Right
Wrist	☐ No	☐ Left	☐ Right
Elbows	☐ No	☐ Left	☐ Right
Shoulders	☐ No	☐ Left	☐ Right
Neck	☐ No	☐ Yes	
Upper back	☐ No	☐ Yes	
Lower back	☐ No	☐ Yes	
Legs/knees/feet	☐ No	☐ Yes	

Other information

Please describe the worst part of your job.

What could be done to improve your job?

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