Ergonomic Intake Form

Thank you for taking the time to complete this form! We know that filling out forms can be tedious, but please know that we use every answer to guide us as we develop recommendations for your workstation. For Y/N questions, please circle the correct answer.

Name:___________________________________ Date:_________________________

What is your occupation?____

How many workstations do you use?____

Do you use a multi-user workstation? Yes No

List tasks involved in your work (e.g., phone use, keyboard use, mouse use, calculator, handwriting, etc.)

____

How much of the day do you use a desktop computer?

____<25% ____25-50% ____>50%

How much of the day do you use a laptop computer?

____<25% ____25-50% ____>50%

How much of the day are you on the telephone? Do you use a headset?

____<25% ____25-50% ____>50% Yes No

What other mobile devices do you use (e.g., iPad, smart phone, dictation machine, etc)?

____

Has your workstation already been evaluated by an ergonomic specialist? Yes No

Are you currently using any specialized ergonomic equipment? Yes No

If yes, please list:____

Do you participate in a structured break program at work? Yes No

Are you required to perform tasks during the day that are away from your desk (e.g., pushing a cart, lifting/carrying documents or equipment, stocking shelves, etc.)? Yes No

If yes, please list:____

Do you wear prescription eyeglasses? Yes No

Contacts?: Yes No

What type? (distance, reading, bi0focals, progressives, computer)______________

When was the last time your eyes were checked?___________________________

Do you smoke? Yes No

Do you drink alcohol? Yes No

If so, how often? ☐ Occasionally ☐ Weekly ☐ Daily

What is your current physical activity level?

- ☐ Sedentary
- ☐ 30 minutes of exercise 1-2x a week, 2-4x a week, everyday (circle frequency)
- ☐ ≥1 hour of exercise 1/2x a week, 2-4x a week, everyday (circle frequency)
- ☐ Avid exercise enthusiast

  Please describe: ____

Do you have difficulty sleeping? Yes No

Do you regularly participate in sports or hobbies that involve repetitive motions (e.g., knitting, tennis, golf, etc.)? Yes No

If yes, please describe: ____

Are you currently experiencing significant and unusual stress in your work or home life?
Yes No

Any recent major life changes (e.g., new baby, job change, death of a loved one)?
Yes No

Have you had therapy this year (e.g., occupational therapy, physical therapy, speech therapy, alternative therapies, acupuncture, etc)? Yes No

Please rate your overall health (circle): Excellent Good Fair Poor

Have you ever had surgery? Yes No

If yes, please describe/include date(s): ____

Please list all medications you are currently taking, including over the counter medications:

____

Do you have any physical problems that we should be aware of? Is there anything else you feel we should know about you? ____

____