



## ERGONOMIC EVALUATION FORM

Please complete the following *before* your evaluation

Name: \_\_\_\_\_

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

Job Title/Occupation: \_\_\_\_\_

Primary Job Functions: \_\_\_\_\_  
 \_\_\_\_\_

Years with current employer: \_\_\_\_\_ yrs.

Year in this occupation: \_\_\_\_\_ yrs.

Previous occupation in the last 5 years (if significantly different from current one): \_\_\_\_\_  
 \_\_\_\_\_

How many hours a day do you spend at work? \_\_\_\_\_ Hrs/day

How much of your day is spent doing the following tasks? Mark an X in the appropriate box for each task.

Task	Never	Occasional (<2hrs/day)	Frequent (2-5 hrs/day)	Constant (5-8+ hrs/day)
Computer				
Telephone Calls				
Meetings				
Filing				
Copying/Faxing				
Stapling/Mailing				
Reviewing Documents or texts				
Handwriting				
Customer Service				
Lifting (Describe below)				
Other (Describe Below)				

Do you wear glasses? \_\_\_\_\_ If yes, what type: computer glasses, bifocals, monofocals, trifocals, progressive lenses? \_  
\_\_\_\_\_

Are you **right**-handed or **left**-handed?

Which phrase best describes your workstation?

- Single Desk
- L-Shaped Desk
- Two separate work areas within room or cubicle

Please mark any of the following that you have in your workstation?

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Keyboard Tray                  | <input type="checkbox"/> Speakerphone                | <input type="checkbox"/> Monitor Filter                     |
| <input type="checkbox"/> Alternate style mouse          | <input type="checkbox"/> Document holder             | <input type="checkbox"/> Monitor riser (raising the height) |
| <input type="checkbox"/> Alternate style keyboard       | <input type="checkbox"/> Footrest                    | <input type="checkbox"/> Filing cabinets                    |
| <input type="checkbox"/> Wrist Rest(s)                  | <input type="checkbox"/> Adjustable chair            | <input type="checkbox"/> Notebooks, folders                 |
| <input type="checkbox"/> Telephone headset              | <input type="checkbox"/> Large-grip pens and pencils |   |
| <input type="checkbox"/> Telephone cradle/shoulder rest | <input type="checkbox"/> Sit/Stand workstation       |   |

Please answer the following questions *based on your position at your computer*:

- |                              |                             |   |
|------------------------------|-----------------------------|---|
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | My hips, knees and elbows are at 90 degrees                       |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | My feet are flat on the floor or a footrest.                      |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | My elbows are under my shoulders when I use my keyboard or mouse. |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | My shoulder are relaxed when typing and when using the mouse.     |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | My wrists are neutral for typing and when using the mouse.        |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | My ears are over my shoulders, not forward.                       |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | I can touch my monitor with my fingertips                         |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | My eyes are in the top 1/3 of my screen                           |

Please answer the following questions about your workstation and work habits:

- |                              |                             |   |
|------------------------------|-----------------------------|---|
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | My pens, paper, stapler and other frequently used items are within easy reach of my primary seat at the workstation |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | My writing desk is uncluttered and the space beneath my desk enables me to move up close to the desk to work.       |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | I use a laptop at work/home   |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | I carry files, laptop and others between work and home  |
|                              |                             | If <b>Yes</b> , please circle your method of transport:   |
|                              |                             | <i>Backpack</i> <i>Shoulder bag</i>   |
|                              |                             | <i>Wheeled backpack</i> <i>Wheeled briefcase</i>  |
|                              |                             | <i>Hard or Soft briefcase</i> <i>Other</i>  |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Do you exercise on a regular basis?   |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Do you stretch on a regular basis?  |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Do you get 7 or more hours of sleep most nights?  |

Please list any concerns you have regarding your condition or work station?: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_