Ergonomic Evaluation

Patient Name:_____ **Date of Report:** / /1____ **Time:** :
LAST FIRST am / pm

MR#_____ ☐ M / ☐ F Age _____ **Onset Date of Condition:** / /1____

Hand Dominant ☐ Right / ☐ Left

Treatment Diagnosis: _____ **ICD-9**: _____ **Physician:** _____

Primary Diagnosis: _____ **Medications**: _____

PMH/PSH/Precautions: _____ ☐ Unremarkable

Chief Complaints

1. _____
2. _____
3. _____
4. _____
5. _____
6. Describe pain (numbness/tingling, soreness, aching, sharp, constant, intermittent, with motion, at rest)_____

Pain: Pain Scale: / 10 Nature: constant / intermittent / localized / radiating

Workstation Layout

Laptop position: _____

Chair:_____

- Height: _____
- Seat depth: _____
- Seat pan angle:_____
- Back support: _____
- Arm rests: _____

Work surface height: _____

Monitor location, height, distance: _____

Keyboard location: _____

Keyboard characteristics: _____

Organization of work zones:_____

- Easy reach zone (16-18 inches in front of body): _____
- Maximum reach zone (26-34 inches in front of body): _____

Areas of mechanical contact stress: _____

Wrist rests: _____

Foot rests: _____

Mouse: _____

- Type: _____
- Location in workstation layout: _____

Telephone:_____

- Location: _____
- Duration of use: _____
- Use of headset: _____

Document holder: _____

Work environment

Lighting and glare: _____
Use of Task lamp: _____
Temperature/air quality: _____
Noise: _____

Patient's Position in Workstation (based on pictures/video)

C-spine: _____
Eye: _____
Shoulder position: _____
+/- Shoulder loading: _____
Elbow position: _____
Wrist position: _____
Lumbar support: _____
Hip angle: _____
Thigh support: _____
Knee position: _____
Foot position: _____
Floor support:_____
Tucked underneath:_____
Unsupported:_____
Habits: _____
Typing style:_____
Wrist planting:_____
Forceful exertions:_____
Awkward Postures:_____
Extended Reach:_____

Work Schedules

Time spent at computer:_____
Typical tasks (phone, dictation, typing, number input, document composition)
_____ duration:
_____ duration:
_____ duration:
_____ duration:
Breaks
Eye rest breaks: _____
Task breaks: _____
Stretch breaks: _____

Habits and Lifestyle Elements

Sleep:_____
Smoking:_____
Exercise:_____
Hydration:_____
Stressors:_____

Objective Measurements

Sensation _____ ☐ intact light touch

Palpation (+) _____ ☐ (-)

Active Range of Motion Deficits: _____

_____

Special tests: _____

_____

Strength assessment: _____

_____

Muscle imbalance syndromes:_____

_____

ASSESSMENT: _____ Tolerated treatment without additional complaints

_____ Patient demonstrates good understanding of program including safety

_____ Patient demonstrates no barriers to learning

_____

_____

Suggested Ergonomic Interventions/Exercises:

_____

_____

_____

_____

PLAN: Patient will follow-up with MD / _____ Clinic on / / 1__ or prn

Patient will be seen for therapy @ _____ **N/A**

Section / Facility

Short Term / Long Term / Patient GOALS (1 visit): Patient will achieve independence in home therapeutic exercise program designed to eliminate functional limitations.

ACHIEVED ☐ **NOT ACHIEVED** ☐

_____

_____

_____

_____

_____ _____

Therapist Printed Name Therapist Signature

Sent to physician on: / / via fax / e-mail / interoffice / mail