Ergonomic Intake Form

Thank you for taking the time to complete this form. The answer to each question will guide us to the source of your pain and ways we can help prevent it.

Name ______________________________ Date ___________________________

What is your occupation? ____

How many workstations do you use? ____

Do you use a multi-user workstation? __Yes __No

What are your typical work tasks? ____

How much of the day do you use a desktop? ___<25% ___25-50% ___>50%

How much of the day do you use a laptop? ___<25% ___25-50% ___>50%

How much of the day are you on the telephone? ___<25% ___25-50% ___ >50%
Do you use a headset? __Yes __No

What type/s of mobile device/s do you use? _______________________________________

Do you use: __IPad __Calculator __Mouse __Other: ______________________________

Has your workstation already been evaluated? __Yes __No

Are you currently using any ergonomic equipment? __Yes __No
If so, please list:____

Do you take breaks throughout the day? __Yes __No

Do you have work tasks during the day that are away from your desk? __Yes __No
If so, please list: ____

Do you wear prescription eyeglasses/contacts? __Yes __No
Type: ____
Last time eyes were checked:_____________________________________

Do you currently smoke? __Yes __No

Do you regularly drink alcohol? __Yes __No
If Yes, _________ drinks per week

What is your current activity level and frequency?_________________________________

Do you have difficulty sleeping? __Yes __No

Do you perform any repetitive motion in hobbies/sports? __Yes __No
If so, Please describe:____

Do you experience significant stress in your work, family or other aspect of life?
__Yes __No

Have you had other therapy this year?
(i.e. OT, PT, speech, psychological) __ Yes __No

Please rate your health:
__Excellent __Good __Fair __ Poor

Have you had any recent major life changes (i.e. new baby, job change, death of loved one)? __Yes __No

Have you ever had surgery? __Yes __No
(If yes, please describe & include dates:)
____
____
____

Please list medications you are currently taking. Include over the counter medications.
____

Have you had any of the following in the past year**?**

__ Bone scan	__EKG (electrocardiogram)
__ CT scan	__ EMG (electromyography)
__ Ultrasound	__ MRI
__X-rays	__ Other _____________

Please check if you've ever had, or *currently* have:

__ Asthma	__ High Blood Pressure
__ Blood Disorder	__ High Blood Sugar/Diabetes
__ Cancer	__ Low Blood Sugar (hypoglycemia)
__ Depression	__ Osteoporosis
__ Head Injury	__ Seizures/Epilepsy
__ Heart Problems	
__Other ________________________________	

Have you had any other physical problems in the past year we should be aware of? (i.e. shortness of breath, insomnia, dizziness): ________________________