Patients' Name: _____

JOB DESCRIPTION

To properly evaluate the effect that your continuing to work will have on your recovery, we need to know the details of your workday usual workday as well as other tasks you are required to perform even occasionally. Please provide answers to all questions. If you do not believe a question applies to you, please mark it "N/A." (*not applicable*)

What is your job? _____

Please give a brief description of your daily job duties. Include activities which you are occasionally asked to perform. _____

_____

USUAL JOB TASKS How much time of each work day do you spend:

_____ Standing - - - - - - - - - - - - - - Type of surface: _____

_____ Sitting - - - - - - - - - - - - - - - Type of Chair: _____

_____ Walking - - - - - - - - - - - - - - What distance: _____

_____ Bending - - - - - - - - - - - - - - How often per hour: _____

_____ Stooping - - - - - - - - - - - - - - How often per hour: _____

_____ Crawling - - - - - - - - - - - - - - How often per hour: _____

_____ Twisting - - - - - - - - - - - - - - How often per hour: _____

_____ Raising arms above head - - - - - - How often per hour: _____

_____ Lifting - - - - - - - - - - Maximum weight how often per hour: _____

_____ Driving - - - - - - - - - - - - - - Type of Vehicle: _____

_____ Operating Equipment - - - - What kind: _____

JOB SATISFACTION

Are you satisfied with your job? ☐ Yes ☐ No

Do you dread going to work each day? ☐ Yes ☐ No

Is your job rewarding? ☐ Yes ☐ No

Have you changed jobs often in the past 5 years? ☐ Yes ☐ No

Is your job in a noisy environment? ☐ Yes ☐ No

Do you feel stress on your job? ☐ Yes ☐ No

Describe: _____

GENERAL

Do you work with others who can assist you to perform heavy work? ☐ Yes ☐ No

Are there "light duty" tasks available for you to request during your recovery? ☐ Yes ☐ No

_____ _____

Date Signature