JOB DEMANDS QUESTIONNAIRE

1. Name and Employment Information

Name:	Job Title:	Hours Per Shift:	Days Per week:
Employer:	Supervisor:	Employer / Supervisor Contact #:	

2. Job Duties Description

Please use the following letters to describe each of following activities:

R (Rarely) *0 to 5% of the time you are at work*	**O** (Occasionally) *Up to 1/3 of the time you are at work*	**F** (Frequently) *1/3 to 2/3's of the time you are at work*	**C** (Constantly) *2/3's to all of the time you are at work*	**N** (Never) *This is not a significant activity you do at work*

Kneeling _____ Crawling _____ Squatting _____ Bending _____

Reaching Above Shoulders _____ Twisting _____ Climbing _____

When you are at work, roughly how much do you lift from……

the floor to your waist? On a daily basis _____ lbs Maximum _____lbs
waist to your shoulders? On a daily Basis _____ lbs Maximum _____lbs
above shoulder height? On a daily Basis _____lbs Maximum _____lbs

On average, during a work day how much are you carrying? (Circle one)

Under 20lbs • *20-30 lbs* • *30-40lbs* • *40lbs or over*

On average how many hours do you? Sit: _____hrs Walk: _____hrs Stand: _____hrs

Do you use your legs/feet for repetitive movement? (circle one) Yes / No

Do you use your arms/hands for repetitive movement? (circle one) Yes / No

What do you feel is your greatest limitation due to your injury? _____

Do you feel you are able to return to work at this point? Yes / No

Do you have any comments or any further information, related to your job, that will be useful in your treatment program? (You can use the back of this paper as well)

_____
_____