

# WORK COMP JOB ANALYSIS QUESTIONNAIRE

Patient Name: \_\_\_\_\_ Acct #: \_\_\_\_\_

What is your occupation or job title? \_\_\_\_\_

What essential activities are required for your job? (Check all that apply)

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Standing            | <input type="checkbox"/> Kneeling                | <input type="checkbox"/> Pushing         |
| <input type="checkbox"/> Walking             | <input type="checkbox"/> Crawling                | <input type="checkbox"/> Pulling         |
| <input type="checkbox"/> Sitting             | <input type="checkbox"/> Climbing Stairs/Ladder  | <input type="checkbox"/> Hand-Pinching   |
| <input type="checkbox"/> Bending/Stooping    | <input type="checkbox"/> Reaching Above Shoulder | <input type="checkbox"/> Hand-Grasping   |
| <input type="checkbox"/> Squatting/Crouching | <input type="checkbox"/> Reaching Forward        | <input type="checkbox"/> Hand-Fine Motor |

Does your job involve lifting and/or carrying? (Check one) ☐ Yes ☐ No

One hand/two hand/alternating? (Check all that apply) ☐ One hand ☐ Two Hands ☐ Alternating

If yes, how much, approximately, are you required to lift and/or carry on a typical work day?

- |                                      |                |
|--------------------------------------|----------------|
| <input type="checkbox"/> <10 lbs.    | Sedentary PDL  |
| <input type="checkbox"/> 11-20 lbs.  | Light PDL      |
| <input type="checkbox"/> 21-50 lbs.  | Medium PDL     |
| <input type="checkbox"/> 51-100 lbs. | Heavy PDL      |
| <input type="checkbox"/> >100 lbs.   | Very Heavy PDL |

What work heights are required for lifting and/or carrying for your job? (Check all that apply)

- |                                      |  |   |
|--------------------------------------|--|---|
| <input type="checkbox"/> Below Waist | <input type="checkbox"/> Waist to Shoulder | <input type="checkbox"/> Above Shoulder |
|--------------------------------------|--|---|

How frequently are you required to lift and/or carry on a typical work day?

- |  |
|--|
| <input type="checkbox"/> Never - 0% (0 hrs.)                 |
| <input type="checkbox"/> Seldom - 1-5% (0 to .5 hrs.)        |
| <input type="checkbox"/> Occasional - 6-33% (.5 to 2.5 hrs.) |
| <input type="checkbox"/> Frequent - 34-66% (2.5 to 5.5 hrs.) |
| <input type="checkbox"/> Constant - 67-100% (>5.5 hrs.)      |

Patient Initials \_\_\_\_\_ Clinician Initials \_\_\_\_\_

(optional) Case Mgr/NCM Date of Communication \_\_\_\_\_