Discomfort Report

UC DAVIS
OCCUPATIONAL HEALTH SERVICES

Date: (mm/dd/yyyy) _____

Job Start Date: (mm/dd/yyyy) _____

Employee Name: _____

Employee Email: _____

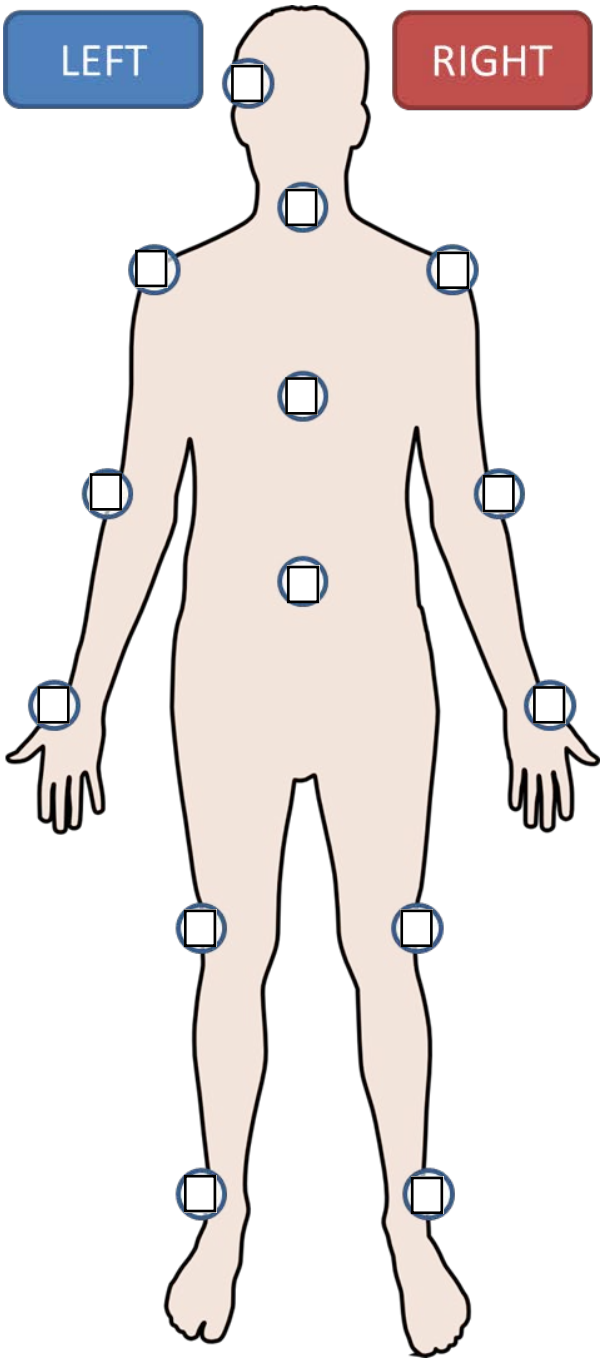
Manager Name: _____

Manager Email: _____

Building Location: _____

Room Number: _____

Fill in the BUBBLE where discomfort is present:



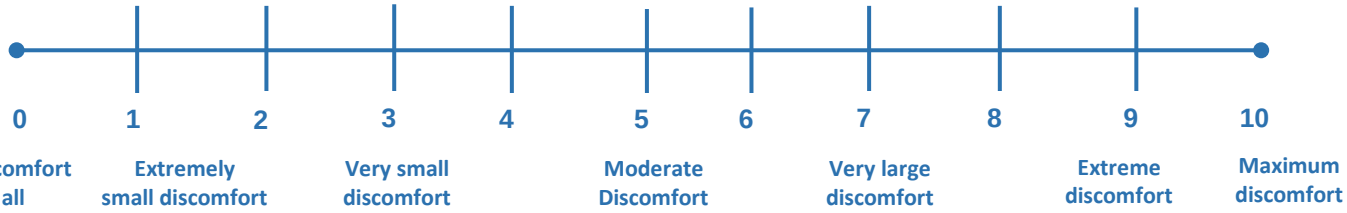
Discomfort Report

UC DAVIS OCCUPATIONAL HEALTH SERVICES

Fill ONLY body parts bubbled in:

Body Part	Incident Date (mm/dd/yyyy)	Medical? (Y/N)	Discomfort (0-10)	Frequency (0-10)	Task Conducted
Eyes					
Neck					
Left Shoulder					
Right Shoulder					
Mid-Back					
Left Elbow					
Right Elbow					
Left Hand/Wrist					
Right Hand/Wrist					
Lower Back					
Left Leg					
Right Leg					
Left Ankle/Foot					
Right Ankle/Foot					

Discomfort Scale Reference:



Frequency Scale Reference: