



# VIRTUAL WORKSPACE ASSESSMENT QUESTIONNAIRE

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We look forward to working with you for a Virtual Ergonomic Assessment. For best results, please complete the following questionnaire with as much detail as possible. The better we understand your working environment, the better we are able to serve your needs.

First and Last Name: \_\_\_\_\_

Company of Employment: \_\_\_\_\_

Job Title: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Email: \_\_\_\_\_

1. What is the mission of your place of employment?

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2. What is the vision of your place of employment?

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3. What is your goal from the Virtual Workspace Assessment? What do you hope to gain?

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4. Please describe the primary occupational tasks that you perform (for example: data entry, shipping and handling of goods, computer programming, design, etc.):

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5. What position are you in most frequently?

Standing

Sitting

Standing and Sitting

6. Please explain what occupational tasks you perform while seated:

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7. Please explain what occupational tasks you perform while standing:

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8. Do you commonly perform hard labor tasks (for example, lifting heavy materials, operating heavy machinery, handling livestock)?

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9. What are the primary safety considerations within your workplace? Do you feel like your workplace is dangerous or hazardous?

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10. Do you perform computer work, if so how many hours per day on average?

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11. Is team collaboration encouraged within your workplace, or do you mainly perform tasks and projects on your own?

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12. Have you consulted with a Wellness Officer or participated in a Corporate Wellness Program before?

Yes

No

If yes, please explain:

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13. Have you completed an Occupational Safety Course or been instructed how to prevent common workplace injuries?

Yes

No

If yes, please explain:

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If no, do you feel like you needed a safety course?

Yes

No

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14. What sicknesses or illnesses do you commonly experience, if any (for example, allergies, headaches, common cold, etc.)?

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15. What type of pain or injuries do you commonly experience, if any (for example, neck pain, back pain, wrist pain, etc.)?

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16. Do you perform repetitive occupational tasks?

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17. Do you commonly work with your arms overhead at high heights, or bending over looking down at low heights?

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18. Do you commonly work in one position for prolonged periods of time without taking breaks?

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19. What hours do you commonly work? Do you often work overtime? Do you work the night shift?

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20. How often do you take breaks throughout the day? Do you choose when to take a break, or is this predetermined?

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21. Do you commonly utilize hand tools? Are they heavy? Are they easy to operate?

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22. Do you ever feel like it is hard to focus or concentrate within your workplace?

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23. What is the average temperature of your working environment? Do you feel comfortable in this temperature?

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24. Are you exposed to vibration within your workplace?

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25. Do you perform work that causes awkward postures?

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26. Do you have easy access, within an arm's reach away, to your most commonly utilized work items?

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27. Would you say that your overall morale is high at work? If not, why do feel that your morale is not high?

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28. Do you work in different locations, or always on-site at the same location?

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29. Do you commonly travel long distances to arrive at work?

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30. Do your occupational tasks require frequent twisting of the spine? Please explain examples of movements that require twisting:

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31. Is your chair and/or desk adjustable to your unique height?

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32. Are there any sharp edges, uneven surfaces, or places where it is easy to trip within your workplace?

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33. What type of flooring is in your workplace? Is it hard floor?

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34. Do you have a hands free option for speaking on the telephone?

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How would you rate your comfort level within your workspace?

- 1 is very uncomfortable
- 2 is uncomfortable
- 3 is neutral, not sure, indifferent
- 4 is comfortable
- 5 is very comfortable

35. Please explain why you selected this level of comfort:

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36. How long are you able to stay in one position before experiencing discomfort?

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37. Do you commonly feel pain after work? Please explain:

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38. Are there any occupational tasks that make you feel fatigued?

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39. Do you usually feel energized at work, or lethargic and tired?

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40. How would you describe your workplace layout (for example, an individual office, a cubicle, an open workspace, etc.)?

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On a scale of 1-5 please rank each aspect of the workplace:

- 1 is very poor condition
- 2 is poor condition
- 3 is neutral, not sure, indifferent
- 4 is good condition
- 5 is excellent condition

41. Do the lights provide adequate light for seeing in your workplace? \_\_\_\_\_

42. Does your computer produce glare? \_\_\_\_\_

43. Is there excess noise within your workplace? \_\_\_\_\_

44. Is your furniture in good condition? \_\_\_\_\_

45. Are items for handling packaged properly and easy to maneuver? \_\_\_\_\_

46. How did you hear about us? \_\_\_\_\_

