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| **Assessors Name:** |  |

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| --- | --- |
| **Assessment Date:** |  |

|  |  |
| --- | --- |
| **Name of Person Assessed:** |  |
| **Date of Birth:** |  |
| **Payroll Number:** |  |
| **Job Title:** |  |

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| --- | --- |
| **Change of Duties:** | |
| Have you changed your duties since you last completed this health questionnaire? If yes, please outline these changes. |  |

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| --- | --- | --- |
| **Recent Experience:** | | |
| **Q1** | Is there currently any movement or activity that causes you pain in your back? |  |
| **Q2** | Have you suffered any back/neck/shoulder pain in the last 12 months? |  |
| **Q3** | On scale of 0 – 10 please describe the level of pain experienced, 0 being no pain. |  |
| **Q4** | Have you had to take any medication to deal with the pain experienced? |  |
| **Q5** | Have you had to seek medical advice regarding this pain? |  |
| **Q6** | Has this back/neck/shoulder pain resulted in time off from work? |  |
| **Q7** | Have you had any accidents or injury to your back in the last two years? |  |
| **Q8** | Do you have any special needs or health restrictions? |  |

|  |  |
| --- | --- |
| **To be Completed by the Employee:** | |
| **I certify that all the answers given above are true to the best of my knowledge and belief.** | |
| **Signature of the person assessed:** |  |

**Notes:**

Q3. If the person’s severity of pain is above 5, or, if they have pain which they rank with a severity of less than 5 on three consecutive assessments, then refer on for further advice.

If the answer is, yes, for any of the questions between 4 and 7, then further advice should be sought from an occupational health professional or GP.

**Action/Advice**

Referral for further advice?

Other advice provided?

|  |  |  |
| --- | --- | --- |
| **To be Completed by the Assessor:** | | |
| **I have carried out this employee assessment on this date:** | |  |
| **Assessors Signature:** |  | |