Work Description Form

When you have filled in the form, please bring it with you to the doctor

Type of work: .................................................................

For how long have you been employed? ☐ Less than a year ☐ 1-5 years ☐ More than 5 years
Employment status: ☐ In work/employed ☐ Unemployed ☐ Rehabilitation
Do you work full- or part-time? ☐ Full-time ☐ Part-time

Name three positive aspects of your work:

1_____________________ 2_____________________ 3____________________

Do you feel your work is physically straining? ☐ No ☐ Yes
If YES, tick off appropriate box(es)
☐ Much sitting ☐ Doing precise movements with hands
☐ Standing still ☐ Doing the same movements many times a minute
☐ Much walking ☐ Working on/with vibrating surface/tools
☐ Kneeling or squatting ☐ Must hold the same position for long periods
☐ Working with arms lifted/reached forward ☐ Heavy work
☐ Lifting many heavy loads ☐ Other:......................

Do you feel your work is mentally straining? ☐ No ☐ Yes
If YES, tick off appropriate box(es)
☐ Have to be alert and concentrated ☐ Have to be creative
☐ Have to deal with emotions ☐ Working with colleagues on tasks
☐ Have to have good memory ☐ Direct client/customer/student contact
☐ Other:......................

Do you feel that the work organization is straining? ☐ No ☐ Yes
If YES, tick off appropriate box(es)
☐ Have shift work ☐ Unclear what is expected at work
☐ Working by contract ☐ Cannot set work pace myself
☐ Have work with high season intensity ☐ Cannot decide myself when to take breaks
☐ Have management responsibilities ☐ Do not get help with the heaviest tasks
☐ Have too much to do ☐ Get little support and help from superiors
☐ Have too much responsibility ☐ Do not feel that my work effort is appreciated
☐ Other:......................