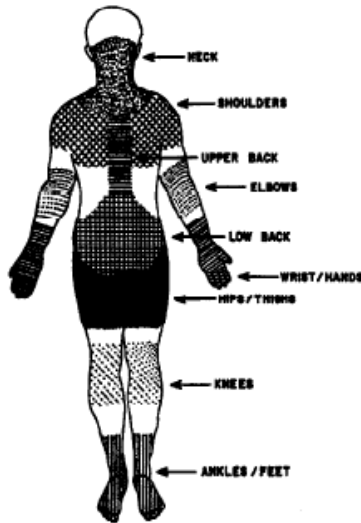


Attachment G4:
Standardized Nordic Questionnaire for Musculoskeletal Symptoms Instrument

How to answer the questionnaire:

Please answer by putting a cross in the appropriate box—one cross for each question. You may be in doubt as to how to answer, but please do your best anyway. Please answer every question, even if you have never had trouble in any part of your body.

In this picture you can see the approximate position of the parts of the body referred to in the questionnaire. Limits are not sharply defined, and certain parts overlap. You should decide for yourself in which part you have or have had your trouble (if any).



Trouble with the locomotive organs		
	To be answered only by those who have had trouble	
Have you at any time during the last 12 months had trouble (ache, pain, discomfort) in:	Have you at any time during the last 12 months been prevented from doing your normal work (at home or away from home) because of the trouble?	Have you had trouble at any time during the last 7 days?
Neck 1 <input type="checkbox"/> No 2 <input type="checkbox"/> Yes	1 <input type="checkbox"/> No 2 <input type="checkbox"/> Yes	1 <input type="checkbox"/> No 2 <input type="checkbox"/> Yes
Shoulders 1 <input type="checkbox"/> No 2 <input type="checkbox"/> Yes, in the right shoulder 3 <input type="checkbox"/> Yes, in the left shoulder 4 <input type="checkbox"/> Yes, in both shoulders	1 <input type="checkbox"/> No 2 <input type="checkbox"/> Yes	1 <input type="checkbox"/> No 2 <input type="checkbox"/> Yes
ELBOWS 1 <input type="checkbox"/> No 2 <input type="checkbox"/> Yes, in the right elbow 3 <input type="checkbox"/> Yes, in the left elbow 4 <input type="checkbox"/> Yes, in both elbows	1 <input type="checkbox"/> No 2 <input type="checkbox"/> Yes	1 <input type="checkbox"/> No 2 <input type="checkbox"/> Yes
Wrists/hands 1 <input type="checkbox"/> No 2 <input type="checkbox"/> Yes, in the right wrist/hand 3 <input type="checkbox"/> Yes, in the left wrist/hand 4 <input type="checkbox"/> Yes, in both wrists/hands	1 <input type="checkbox"/> No 2 <input type="checkbox"/> Yes	1 <input type="checkbox"/> No 2 <input type="checkbox"/> Yes
Upper back 1 <input type="checkbox"/> No 2 <input type="checkbox"/> Yes	1 <input type="checkbox"/> No 2 <input type="checkbox"/> Yes	1 <input type="checkbox"/> No 2 <input type="checkbox"/> Yes
Low back (small of the back) 1 <input type="checkbox"/> No 2 <input type="checkbox"/> Yes	1 <input type="checkbox"/> No 2 <input type="checkbox"/> Yes	1 <input type="checkbox"/> No 2 <input type="checkbox"/> Yes
One or both hips/thighs 1 <input type="checkbox"/> No 2 <input type="checkbox"/> Yes	1 <input type="checkbox"/> No 2 <input type="checkbox"/> Yes	1 <input type="checkbox"/> No 2 <input type="checkbox"/> Yes
One or both knees 1 <input type="checkbox"/> No 2 <input type="checkbox"/> Yes	1 <input type="checkbox"/> No 2 <input type="checkbox"/> Yes	1 <input type="checkbox"/> No 2 <input type="checkbox"/> Yes
One or both ankles/feet 1 <input type="checkbox"/> No 2 <input type="checkbox"/> Yes	1 <input type="checkbox"/> No 2 <input type="checkbox"/> Yes	1 <input type="checkbox"/> No 2 <input type="checkbox"/> Yes

Public reporting burden of this collection of information is estimated to average 4 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to a collection of information unless it displays a currently valid OMB control number. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to CDC/ATSDR Information Collection Review Office, 1600 Clifton Road NE, MS D-74, Atlanta, Georgia 30333; ATTN: PRA (0920-XXXX).