CONFIDENTIAL

University of Michigan

Upper Extremity Questionnaire

MARKING DIRECTIONS

- Use No. 2 pencil only.
- Do not use ink, ballpoint, or felt tip pens.
- Make solid marks that fill the circle completely.
- Erase cleanly any marks you wish to change.
- Make no stray marks on this form.
- Do not fold, tear, or mutilate this form.

INCORRECT MARKS ⊘ ⊗ ◒ ⊙ CORRECT MARK ●

1 YOUR NAME:

LAST NAME | FIRST NAME | MI

2 ID NUMBER:

3 TODAY'S DATE:

MONTH	DAY	YEAR
○ Jan.		
○ Feb.		
○ Mar.	0 0	0 0
○ Apr.	1 1	1 1
○ May	2 2	2 2
○ June	3 3	3 3
○ July	4	4 4
○ Aug.	5	5 5
○ Sept.	6	6 6
○ Oct.	7	7 7
○ Nov.	8	8 8
○ Dec.	9	9 9

4 THE TIME RIGHT NOW:

0 0 0 0 / 1 1 1 1 ○ A.M.

2 2 2 / 3 3 3 / 4 4 4 / 5 5 5 ○ P.M.

6 6 / 7 7 / 8 8 / 9 9

5 YOUR BIRTH DATE:

MONTH	DAY	YEAR
○ Jan.		
○ Feb.		
○ Mar.	0 0	0 0
○ Apr.	1 1	1 1
○ May	2 2	2 2
○ June	3 3	3 3
○ July	4	4 4
○ Aug.	5	5 5
○ Sept.	6	6 6
○ Oct.	7	7 7
○ Nov.	8	8 8
○ Dec.	9	9 9

6 RACE: (mark only one)

- ○ White (not Hispanic)
- ○ Black/African American
- ○ Asian/Asian American
- ○ Hispanic
- ○ Other: _____

7 ARE YOU:

- ○ Male
- ○ Female

8 ARE YOU:

- ○ Right-handed
- ○ Left-handed

(If not sure, mark the hand you use to sign your name)

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PLEASE DO NOT WRITE IN THIS AREA

9 YOUR HOME ADDRESS:

STREET | APT. NUMBER

10 CITY | STATE

11 ZIP CODE

12 YOUR HOME TELEPHONE NUMBER:

AREA CODE

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13a. Have you ever been told by a medical doctor that you have any of the following problems?

Please mark "No" or "Yes." If you don't recognize a name or are not sure, mark "No."

Systemic Illness or Disease	No	Yes
Diabetes (excluding diabetes solely related to pregnancy)	N	Y
Rheumatoid arthritis	N	Y
Low thyroid or overactive thyroid	N	Y
Chronic renal failure	N	Y
Gout	N	Y
Fibromyalgia	N	Y
Degenerative arthritis	N	Y
Other systemic illness (please describe):	N	Y

13b. Have you ever been told by a medical doctor that you have any of the following problems? Please mark "No" or "Yes" for the right and left sides. If you don't recognize a name or are not sure, mark "No."

Localized Injury or Disease	Right Side		Left Side	
	No	Yes	No	Yes
Cervical radiculopathy ("pinched nerve" in the neck)	N	Y	N	Y
Carpal Tunnel Syndrome	N	Y	N	Y
Ulnar neuropathy	N	Y	N	Y
Tendinitis in the fingers, hands, wrists, forearms, or elbows	N	Y	N	Y
Tendinitis in the shoulders	N	Y	N	Y
Broken bones in the fingers, hands, wrists, forearms, or elbows	N	Y	N	Y
Broken bones in the upper arms or shoulders	N	Y	N	Y
Thoracic outlet syndrome	N	Y	N	Y
Rotator cuff injury	N	Y	N	Y
Ganglion	N	Y	N	Y
Muscle strain/sprain in the fingers, hands, wrists, forearms or elbows	N	Y	N	Y
Muscle strain/sprain in the upper arms or shoulders	N	Y	N	Y
Other localized injury or illness (please describe):	N	Y	N	Y

Continue on page 4

PLEASE DO NOT WRITE IN THIS AREA

14. **Are you related to anyone who has had a nerve and/or muscle disease?** ○ No ○ Yes
If "Yes," please describe it and explain who had the disease:

15. **What medicines are you currently taking, including non-prescription medications?**
(If none, write "none")

16. **Have you ever had any surgery on your neck, shoulders, arms, wrists, hands, or fingers?** ○ No ○ Yes
If "Yes," please describe it:

	Description	*Side (R or L)*	*Year*
A)	_____	Ⓡ Ⓛ	19 ⓪①②③④⑤⑥⑦⑧⑨ ⓪①②③④⑤⑥⑦⑧⑨
B)	_____	Ⓡ Ⓛ	19 ⓪①②③④⑤⑥⑦⑧⑨ ⓪①②③④⑤⑥⑦⑧⑨
C)	_____	Ⓡ Ⓛ	19 ⓪①②③④⑤⑥⑦⑧⑨ ⓪①②③④⑤⑥⑦⑧⑨

17. **If you are female, please answer the following questions:**

Are you pregnant? ○ No ○ Yes *If "Yes," how many weeks?* → ⓪①②③④⑤⑥⑦⑧⑨ ⓪①②③④⑤⑥⑦⑧⑨

Are you currently taking birth control pills? ○ No ○ Yes

Have you had surgery that resulted in removal of <u>both ovaries</u>?
○ No
○ Yes

Have you had surgery that resulted in removal of the <u>uterus</u>?
○ No
○ Yes

Have you passed menopause? (note: this refers to natural menopause)
○ No
○ Yes

18. **Do you participate in any form of regular physical exercise (for example, walking, jogging, aerobics, or organized sports)?**
○ No
○ Yes *If "Yes," mark the one category which best matches your typical frequency of participation in this activity:*
- ○ less than once a month
- ○ once a month but less than once a week
- ○ once or twice per week
- ○ three or more times per week

Continue on page 5

NECK/SHOULDER/UPPER ARM PROBLEMS

19. In the past year, have you had RECURRING problems with your NECK, SHOULDERS or UPPER ARMS more than 3 times or lasting more than one week? (Do not include problems with your elbows, forearms, hands or wrists.)

○ No *Skip to page 7*
○ Yes

20. If "Yes," please describe the location and type of symptoms you are having by marking the responses below, where appropriate. Mark as many responses as necessary.
For example, if you are experiencing stiffness and cramping in your neck, mark those two responses under "neck."

	Neck	*Right Shoulder*	*Left Shoulder*	*Right Upper Arm*	*Left Upper Arm*
Burning	○	○	○	○	○
Stiffness	○	○	○	○	○
Pain	○	○	○	○	○
Cramping	○	○	○	○	○
Tightness	○	○	○	○	○
Aching	○	○	○	○	○
Soreness	○	○	○	○	○
Tingling	○	○	○	○	○
Numbness	○	○	○	○	○

21. In the last 7 days my neck, shoulder and upper arm symptoms have interfered with my production rates and/or my usual standard of quality (mark the single best answer):

Strongly Agree ① ② ③ ④ ⑤ *Strongly Disagree*

22. Do you think these problems are associated with a particular work station or work activity? ○ No ○ Yes
If yes, please describe:

Body area (neck, left shoulder, etc.)	**Work station or work activity**
_____	_____
_____	_____
_____	_____

23. If you are having symptoms in more than one area, please tell us which area is the worst:
(*mark only one body area*)

○ Neck
○ Right shoulder
○ Left shoulder
○ Right upper arm
○ Left upper arm

Continue on page 6

PLEASE DO NOT WRITE IN THIS AREA

***For the rest of this section on neck, shoulder, and upper arms, answer for the area where you are experiencing the worst symptoms**, as you marked in the last question:*

24. When did you first experience this problem? → MO. YEAR

25. How many separate episodes of this problem have you had in the past year: (*mark only one*)
- ◯ 3 to 12 episodes
- ◯ 13 to 36 episodes
- ◯ 37 to 52 episodes
- ◯ 53 to 150 episodes
- ◯ more than 150
- ◯ continuous

26. How long does each episode of this problem usually last? (*mark only one*)
- ◯ 1 hour or less
- ◯ more than an hour, but less than a day
- ◯ more than a day, but less than a week
- ◯ more than a week, but less than a month
- ◯ more than a month

27. How much discomfort are you feeling in this area right now? Rate your discomfort on a scale of zero to ten with zero being 'no discomfort' and ten being the 'worst discomfort imaginable.' Please fill in the number below which best matches your level of discomfort. (*mark only one discomfort category*)

No discomfort — *Worst discomfort imaginable*

0 1 2 3 4 5 6 7 8 9 10

28. What has been the worst discomfort you have felt in this area in the last 30 days? Rate your discomfort on a scale of zero to ten with zero being 'no discomfort' and ten being the 'worst discomfort imaginable.' Please fill in the number below which best matches your level of discomfort. (*mark only one discomfort category*)

No discomfort — *Worst discomfort imaginable*

0 1 2 3 4 5 6 7 8 9 10

29. Was this problem caused by a particular event such as an accident or injury? ◯ No ◯ Yes

30. Have you had any treatment for this problem, either by a medical professional or by yourself? ◯ No ◯ Yes
If yes, please mark those which apply:
- ◯ rest
- ◯ icing
- ◯ surgery
- ◯ other - describe _____
- ◯ anti-inflammatory medications
- ◯ physical therapy
- ◯ steroid injection

Continue on page 7

ELBOW/FOREARM PROBLEMS

31. **In the past year, have you had RECURRING problems with your ELBOWS or FOREARMS more than 3 times or lasting more than one week? (Do not include problems with your neck, shoulders, upper arms, hands or wrists.)**
- ◯ No *Skip to page 8*
- ◯ Yes

32. **If "Yes," please describe the location and type of symptoms you are having by marking the responses below, where appropriate. Mark as many as necessary.**
For example, if you are experiencing stiffness and cramping in your right forearm, mark those two responses under "right forearm."

	Right Elbow	*Left Elbow*	*Right Forearm*	*Left Forearm*
Burning	◯	◯	◯	◯
Stiffness	◯	◯	◯	◯
Pain	◯	◯	◯	◯
Cramping	◯	◯	◯	◯
Tightness	◯	◯	◯	◯
Aching	◯	◯	◯	◯
Soreness	◯	◯	◯	◯
Tingling	◯	◯	◯	◯
Numbness	◯	◯	◯	◯

33. **In the last 7 days my elbow and forearm symptoms have interfered with my production rates and/or my usual standard of quality (mark the single best answer):**

Strongly Agree ① ② ③ ④ ⑤ *Strongly Disagree*

34. **Do you think these problems are associated with a particular work station or work activity?** ◯ No ◯ Yes
If yes, please describe:

Body area (left elbow, etc.)	**Work station or work activity**
_____	_____
_____	_____
_____	_____

35. **If you are having symptoms in more than one area, please tell us which area is the worst:**
(*mark only one body area*)
- ◯ Right elbow
- ◯ Left elbow
- ◯ Right forearm
- ◯ Left forearm

Continue on page 8

PLEASE DO NOT WRITE IN THIS AREA

For the rest of this section on elbows and forearms, answer for <u>the area where you are experiencing the worst symptoms</u>, as you marked in the last question:

36. When did you first experience this problem? → MO. YEAR

37. How many <u>separate episodes</u> of this problem have you had in the past year: (*mark only <u>one</u>*)

- ◯ 3 to 12 episodes
- ◯ 13 to 36 episodes
- ◯ 37 to 52 episodes
- ◯ 53 to 150 episodes
- ◯ more than 150
- ◯ continuous

38. How long does each episode of this problem usually last? (*mark only <u>one</u>*)

- ◯ 1 hour or less
- ◯ more than an hour, but less than a day
- ◯ more than a day, but less than a week
- ◯ more than a week, but less than a month
- ◯ more than a month

39. How much discomfort are you feeling in this area <u>right now</u>? Rate your discomfort on a scale of zero to ten with zero being 'no discomfort' and ten being the 'worst discomfort imaginable.' Please fill in the number below which best matches your level of discomfort. (*mark only one discomfort category*)

No discomfort — *Worst discomfort imaginable*

0 1 2 3 4 5 6 7 8 9 10

40. What has been the worst discomfort you have felt in this area <u>in the last 30 days</u>? Rate your discomfort on a scale of zero to ten with zero being 'no discomfort' and ten being the 'worst discomfort imaginable.' Please fill in the number below which best matches your level of discomfort. (*mark only one discomfort category*)

No discomfort — *Worst discomfort imaginable*

0 1 2 3 4 5 6 7 8 9 10

41. Was this problem caused by a particular event such as an accident or injury? ◯ No ◯ Yes

42. Have you had any treatment for this problem, either by a medical professional or by yourself? ◯ No ◯ Yes

If yes, please mark those which apply:

- ◯ rest
- ◯ icing
- ◯ surgery
- ◯ other - describe _____
- ◯ anti-inflammatory medications
- ◯ physical therapy
- ◯ steroid injection

HAND/WRIST/FINGER PROBLEMS

43. In the past year, have you had RECURRING problems with your HANDS, WRISTS or FINGERS more than 3 times or lasting more than one week? (Do not include problems with your neck, shoulders, upper arms, elbows, or forearms.)

- ◯ No *Skip to page 11 (OVERALL PROBLEMS/WORK HISTORY)*
- ◯ Yes

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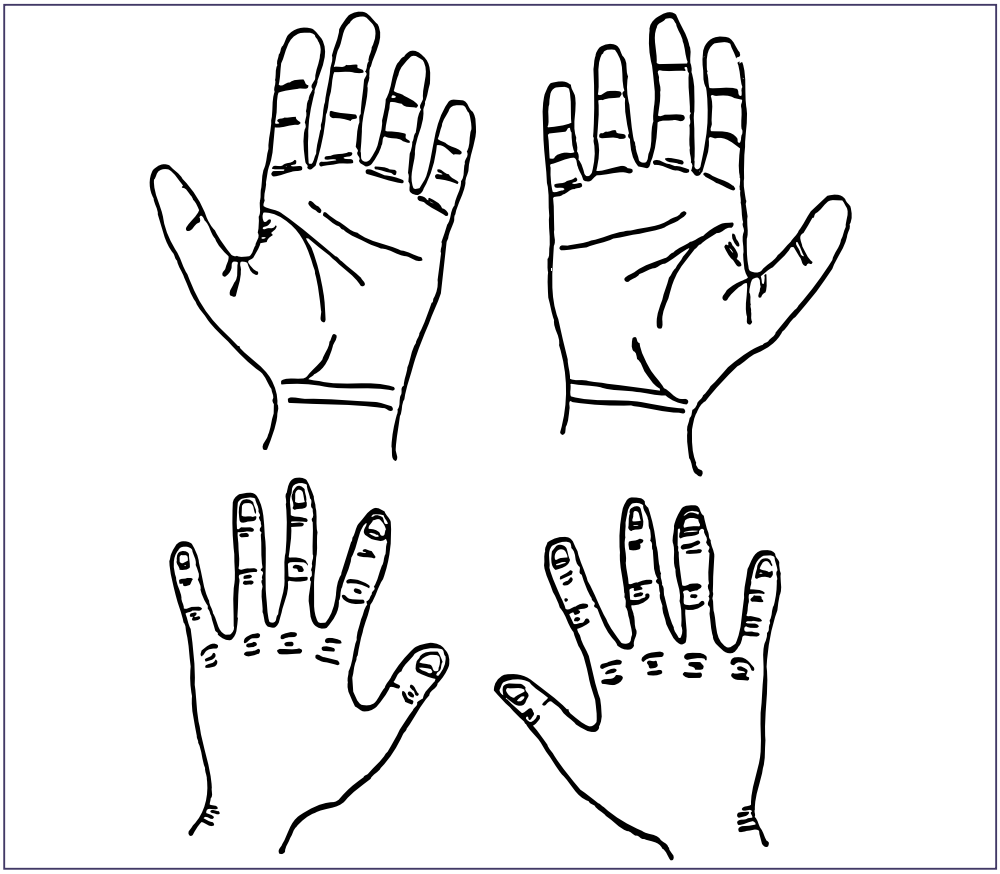
44. **If "Yes," please describe the location and type of symptoms you are having by marking the responses below, where appropriate. Mark as many responses as necessary.**
For example, if you are experiencing stiffness and cramping in your right fingers, mark those two responses under "right fingers."

	Right Wrist	*Left Wrist*	*Right Hand*	*Left Hand*	*Right Fingers*	*Left Fingers*
Burning	○	○	○	○	○	○
Stiffness	○	○	○	○	○	○
Pain	○	○	○	○	○	○
Cramping	○	○	○	○	○	○
Tightness	○	○	○	○	○	○
Aching	○	○	○	○	○	○
Soreness	○	○	○	○	○	○
Tingling	○	○	○	○	○	○
Numbness	○	○	○	○	○	○

45. **If in the previous question you indicated NO problems with <u>numbness, tingling, burning, or pain</u>, then skip to question 46 now. Otherwise, please show on the diagram at right where you have experienced <u>numbness, tingling, burning, or pain</u>, by shading in the problem area(s).**



Continue on page 10

46. In the last 7 days my wrist, hand and finger symptoms have interfered with my production rates and/or my usual standard of quality (mark the single best answer):

Strongly Agree				*Strongly Disagree*
①	②	③	④	⑤

47. Do you think these problems are associated with a particular work station or work activity? ◯ No ◯ Yes
If yes, please describe:

Body area (right wrist, etc.)	**Work station or work activity**
_____	_____
_____	_____
_____	_____

48. Have these problems ever awakened you from sleep? ◯ No ◯ Yes ◯ right ◯ left

49. If you are having symptoms in more than one area, please tell us which area is the worst: (*mark only one body area*)

◯ Right wrist
◯ Left wrist
◯ Right hand
◯ Left hand
◯ Right fingers
◯ Left fingers

For the rest of this section on hands, wrists, and fingers, answer for the area where you are experiencing the worst symptoms, as you marked in the last question:

50. When did you first experience this problem? → MO. YEAR

51. How many separate episodes of this problem have you had in the past year: (*mark only one*)

◯ 3 to 12 episodes
◯ 13 to 36 episodes
◯ 37 to 52 episodes
◯ 53 to 150 episodes
◯ more than 150
◯ continuous

52. How long does each episode of this problem usually last? (*mark only one*)

◯ 1 hour or less
◯ more than an hour, but less than a day
◯ more than a day, but less than a week
◯ more than a week, but less than a month
◯ more than a month

53. How much discomfort are you feeling in this area right now? Rate your discomfort on a scale of zero to ten with zero being 'no discomfort' and ten being the 'worst discomfort imaginable.' Please fill in the number below which best matches your level of discomfort. (*mark only one discomfort category*)

No discomfort										*Worst discomfort imaginable*
0	1	2	3	4	5	6	7	8	9	10

Continue on page 11

PLEASE DO NOT WRITE IN THIS AREA

54. **What was the worst discomfort you felt in this area <u>in the last 30 days</u>? Rate your discomfort on a scale of zero to ten with zero being 'no discomfort' and ten being the 'worst discomfort imaginable.' Please fill in the number below which best matches your level of discomfort. (*mark only one discomfort category*)**

No discomfort — *Worst discomfort imaginable*

0 1 2 3 4 5 6 7 8 9 10

55. **Was this problem caused by a particular event such as an accident or injury?** ◯ No ◯ Yes

56. **Have you had any treatment for this problem, either by a medical professional or by yourself?** ◯ No ◯ Yes
If yes, please mark those which apply:

- ◯ rest
- ◯ icing
- ◯ surgery
- ◯ other - describe _____
- ◯ anti-inflammatory medications
- ◯ physical therapy
- ◯ steroid injection

OVERALL PROBLEMS/WORK HISTORY

57. **If you indicated problems on more than one section of this questionnaire (neck/shoulder/upper arm, elbow/forearm, and wrist/hand/fingers), mark which area is the <u>worst</u>:**

- ◯ neck/shoulder/upper arm
- ◯ elbow/forearm
- ◯ wrist/hand/fingers

58. **Do you currently have another job in addition to this one?**

- ◯ No
- ◯ Yes → **Hours Per Week**

0	0
1	1
2	2
3	3
4	4
5	5
6	6
7	7
8	8
9	9

If Yes, please describe it:

_____

59. **How tall are you without shoes?** →

HEIGHT	
FT.	IN.
3	1 7
4	2 8
5	3 9
6	4 10
7	5 11
8	6

60. **How much do you weigh while wearing light clothing, but no shoes?** →

WEIGHT (*in pounds*)		
0	0	0
1	1	1
2	2	2
3	3	3
4	4	4
5	5	5
6	6	6
7	7	7
8	8	8
9	9	9

61. **Are you a member of a union or employee association?**

- ◯ No
- ◯ Yes

62. **What is your current annual income?**

- ◯ less than $10,000
- ◯ $10,000 to $19,999
- ◯ $20,000 to $29,999
- ◯ $30,000 to $39,999
- ◯ $40,000 to $49,999
- ◯ more than $49,999

63. **Have you ever smoked cigarettes? (*"No" means less than 20 packs of cigarettes or 12 oz. of tobacco in a lifetime or less than 1 cigarette a day for 1 year*)**

- ◯ Yes
- ◯ No

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If No to 63, go to question 70.

64. Do you now smoke cigarettes (as of one month ago)?

◯ Yes ◯ No ◯ Does not apply

65. How old were you when you first started regular cigarette smoking?

Age started

◯ Does not apply

66. If you have stopped smoking cigarettes completely, how old were you when you stopped?

Age stopped

◯ Mark if still smoking

◯ Does not apply

67. How many cigarettes do you smoke per day now?

Cigarettes per day

◯ Does not apply

68. What is the total number of years you have smoked?

Years smoked

◯ Does not apply

69. On the average of the entire time you smoked, how many cigarettes did you smoke per day?

Cigarettes per day

◯ Does not apply

70. What is the highest level of schooling you have completed (*please mark only one category*)?

◯ Grade eight or less
◯ Some high school
◯ Graduated high school
◯ Two year junior college or technical institute after high school
◯ Attended 4 year college, did not graduate
◯ Graduated four year college
◯ Attended graduate or professional school

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PLEASE DO NOT WRITE IN THIS AREA

PART 2

1. **Please answer all of the following questions in order. There are no right or wrong answers. ALL YOUR ANSWERS WILL BE KEPT CONFIDENTIAL.**
2. **Most questions can be answered by marking the alternative that describes your choice. Sometimes none of the answers fit exactly. Please choose the answer that comes closest. Here is an example:**

	Strongly disagree	*Disagree*	*Agree*	*Strongly agree*
Example 1. The people I work with are friendly.	①	②	●	④

3. **Other questions can be answered by marking the number that best represents your view:**

	Never		*Sometimes*		*Always*
Example 2. I think about quitting this job.	①	②	●	④	⑤

4. **Still other questions can be answered by marking the circle next to the question.**

Example 3. Do you work with hand tools? ● Yes ○ No

5. **If you don't want to answer a question, just skip it.**

Please answer each question by marking the number that best describes how much you agree or disagree with each statement.

	Strongly disagree	*Disagree*	*Agree*	*Strongly agree*
A1. My job requires me to be creative.	①	②	③	④
A2. My job requires that I learn new things.	①	②	③	④
A3. My job involves a lot of repetitive work.	①	②	③	④
A4. I have an opportunity to develop my own special abilities.	①	②	③	④
A5. On my job, I have very little freedom to decide how I do my work.	①	②	③	④
A6. My job allows me to make a lot of decisions on my own.	①	②	③	④
A7. My job requires a high level of skill.	①	②	③	④
A8. I get to do a variety of different things on my job.	①	②	③	④
A9. I have a lot to say about what happens on my job.	①	②	③	④
A10. People I work with are competent in doing their jobs.	①	②	③	④
A11. People I work with take a personal interest in me.	①	②	③	④
A12. I am exposed to hostility or conflict from the people I work with.	①	②	③	④
A13. The people I work with are friendly.	①	②	③	④
A14. The people I work with encourage each other to work together.	①	②	③	④

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		Strongly disagree	*Disagree*	*Agree*	*Strongly agree*	
A15.	**People I work with are helpful in getting the job done.**	①	②	③	④	
A16.	**My job security is good.**	①	②	③	④	
		Strongly disagree	*Disagree*	*Agree*	*Strongly agree*	*I have no supervisor*
A17.	**My supervisor is concerned about the welfare of those under him/her.**	①	②	③	④	⑧
A18.	**My supervisor pays attention to what I am saying.**	①	②	③	④	⑧
A19.	**I am exposed to hostility or conflict from my supervisor.**	①	②	③	④	⑧
A20.	**My supervisor is helpful in getting the job done.**	①	②	③	④	⑧
A21.	**My supervisor is successful in getting people to work together.**	①	②	③	④	⑧
		I work alone	*2 - 5 people*	*6 - 9 people*	*10 - 19 people*	*20 or more people*
A22.	**How many people are in your work group or unit?**	①	③	⑧	⑮	㉚
		No	*Yes, 1 - 4 people*	*Yes, 5 - 10 people*	*Yes, 11 - 20 people*	*Yes, 20 or more people*
A23.	**I supervise other people as part of my job.**	①	②	③	④	⑤
			Not at all	*Not too*	*Somewhat*	*Very*
A24.	**How satisfied are you with your job?**		①	②	③	④
			Advise against it	*Have doubts about it*	*Strongly recommend it*	
A25.	**Would you advise a friend to take this job?**		①	③	⑤	
			Take without hesitation	*Have second thoughts*	*Definitely not*	
A26.	**Would you take this job again?**		①	③	⑤	
			Very likely	*Somewhat*	*Not at all*	
A27.	**How likely is it that you will find a new job in the next year?**		①	③	⑤	
			Very much like	*Somewhat like*	*Not very much like*	
A28.	**Is this job what you wanted when you applied for it?**		①	③	⑤	
		Regular and steady	*Seasonal*	*Frequent layoffs*	*Both seasonal and frequent layoffs*	*Other*
A29.	**How steady is your work? (Mark one.)**	①	④	④	④	⑨
			Not at all likely	*Not too likely*	*Somewhat likely*	*Very likely*
A30.	**Sometimes people permanently lose jobs they want to keep. How likely is it that during the next couple of years you will lose your present job with your employer?**		①	②	③	④

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PLEASE DO NOT WRITE IN THIS AREA

PART 2, continued

The questions in this scale ask you about your feelings and thoughts during the last month. In each case, you will be asked to indicate *how often* you felt or thought a certain way. Although some of the questions are similar, there are differences between them and you should treat each one as a separate question. The best approach is to answer each question fairly quickly. That is, don't try to count up the number of times you felt a particular way, but rather indicate the alternative that seems like a reasonable estimate.

For each question choose from the following alternatives:

0. never 1. almost never 2. sometimes 3. fairly often 4. very often

	Never	*Almost never*	*Sometimes*	*Fairly often*	*Very often*
B1. In the last month, how often have you been upset because of something that happened unexpectedly?	⓪	①	②	③	④
B2. In the last month, how often have you felt that you were unable to control the important things in your life?	⓪	①	②	③	④
B3. In the last month, how often have you felt nervous and "stressed"?	⓪	①	②	③	④
B4. In the last month, how often have you dealt successfully with irritating life hassles?	⓪	①	②	③	④
B5. In the last month, how often have you felt that you were effectively coping with important changes that were occurring in your life?	⓪	①	②	③	④
B6. In the last month, how often have you felt confident about your ability to handle your personal problems?	⓪	①	②	③	④
B7. In the last month, how often have you felt that things were going your way?	⓪	①	②	③	④
B8. In the last month, how often have you found that you could not cope with all the things that you had to do?	⓪	①	②	③	④
B9. In the last month, how often have you been able to control irritations in your life?	⓪	①	②	③	④
B10. In the last month, how often have you felt that you were on top of things?	⓪	①	②	③	④
B11. In the last month, how often have you been angered because of things that happened that were outside of your control?	⓪	①	②	③	④
B12. In the last month, how often have you found yourself thinking about things that you have to accomplish?	⓪	①	②	③	④
B13. In the last month, how often have you been able to control the way you spend your time?	⓪	①	②	③	④
B14. In the last month, how often have you felt difficulties were piling up so high that you could not overcome them?	⓪	①	②	③	④

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This section asks about people you work with and your relations with them. Please remember that your answers are completely confidential. We are interested in the social network you have at work.

1. _____
2. _____
3. _____
4. _____
5. _____

C1. List the initials of up to five co-workers, including supervisors, with whom you discuss *important* matters.

All of the questions should be answered by marking one of the letters for each person that you listed in Question C1. If you don't find an answer that fits exactly, use the one that comes closest. If any question does not apply to you, or you are not sure what it means, please leave it blank.

	Person 1	*Person 2*	*Person 3*	*Person 4*	*Person 5*
Please write in the person's initials	_____	_____	_____	_____	_____
C2. How often do you talk to this person:					
(A) at least once a month	Ⓐ	Ⓐ	Ⓐ	Ⓐ	Ⓐ
(B) at least once a week	Ⓑ	Ⓑ	Ⓑ	Ⓑ	Ⓑ
(C) 2-3 times a week	Ⓒ	Ⓒ	Ⓒ	Ⓒ	Ⓒ
(D) every day	Ⓓ	Ⓓ	Ⓓ	Ⓓ	Ⓓ
C3. Has this person complained of hand, wrist, elbow, or shoulder discomfort in the last four weeks, such as pain, cramping, burning, tingling (pins and needles), or stiffness:					
(Y) Yes	Ⓨ	Ⓨ	Ⓨ	Ⓨ	Ⓨ
(N) No	Ⓝ	Ⓝ	Ⓝ	Ⓝ	Ⓝ
(X) Don't know	Ⓧ	Ⓧ	Ⓧ	Ⓧ	Ⓧ
C4. Has this person formally reported hand, wrist, elbow, or shoulder discomfort as work related in the last four weeks:					
(Y) yes	Ⓨ	Ⓨ	Ⓨ	Ⓨ	Ⓨ
(N) no	Ⓝ	Ⓝ	Ⓝ	Ⓝ	Ⓝ
(X) don't know	Ⓧ	Ⓧ	Ⓧ	Ⓧ	Ⓧ
C5. Have you discussed remedies for easing hand, wrist, elbow, or shoulder discomfort with this person in the last four weeks:					
(Y) yes	Ⓨ	Ⓨ	Ⓨ	Ⓨ	Ⓨ
(N) no	Ⓝ	Ⓝ	Ⓝ	Ⓝ	Ⓝ
C6. Does this person work:					
(A) next to you	Ⓐ	Ⓐ	Ⓐ	Ⓐ	Ⓐ
(B) not next to you, but in the same room	Ⓑ	Ⓑ	Ⓑ	Ⓑ	Ⓑ
(C) in the same building	Ⓒ	Ⓒ	Ⓒ	Ⓒ	Ⓒ
(O) other _____	Ⓞ	Ⓞ	Ⓞ	Ⓞ	Ⓞ
C7. Is this person:					
(M) Male	Ⓜ	Ⓜ	Ⓜ	Ⓜ	Ⓜ
(F) Female	Ⓕ	Ⓕ	Ⓕ	Ⓕ	Ⓕ
C8. Is this person:					
(A) Asian/Asian American	Ⓐ	Ⓐ	Ⓐ	Ⓐ	Ⓐ
(B) Black/African American	Ⓑ	Ⓑ	Ⓑ	Ⓑ	Ⓑ
(H) Hispanic	Ⓗ	Ⓗ	Ⓗ	Ⓗ	Ⓗ
(W) White	Ⓦ	Ⓦ	Ⓦ	Ⓦ	Ⓦ
(O) Other _____	Ⓞ	Ⓞ	Ⓞ	Ⓞ	Ⓞ
C9. Is this person's age:					
(A) under 20	Ⓐ	Ⓐ	Ⓐ	Ⓐ	Ⓐ
(B) 20-29	Ⓑ	Ⓑ	Ⓑ	Ⓑ	Ⓑ
(C) 30-39	Ⓒ	Ⓒ	Ⓒ	Ⓒ	Ⓒ
(D) 40-49	Ⓓ	Ⓓ	Ⓓ	Ⓓ	Ⓓ
(E) 50-59	Ⓔ	Ⓔ	Ⓔ	Ⓔ	Ⓔ
(F) 60 and over	Ⓕ	Ⓕ	Ⓕ	Ⓕ	Ⓕ

You have finished this questionnaire! Thank you for your time and effort.

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