Appendix A. Radiation Therapist Survey

1.1. A Survey of Radiation Therapists' Work-Related Musculoskeletal Injuries

The purpose of this study is to improve the understanding of the physical and mental challenges experienced by Radiation Therapists, and the factors that could contribute to workplace injury. The content of this questionnaire does not evaluate your performance at work. The focus of the questionnaire is musculoskeletal discomfort and associated risk factors, which is an under-studied area of Radiation Therapist’s health.

This questionnaire will take about 40 minutes of your time (based on our pilot testing). You may complete it in one effort, or complete a few questions each day over a few days. The questionnaire includes questions about your work, work load perceptions, physical activity at work, psychosocial aspects of your work, workspace design, your musculoskeletal health, and some demographic information.

In the musculoskeletal health part of the questionnaire, we are asking about different body parts on separate pages. If you do not experience discomfort in some of the body parts, you will be able to skip pages after answering just one or two questions on those pages.

Your participation in this study is voluntary. Your answers will be treated confidentially. An informed consent form is included.

Your help is needed to make this research study a success! Whether or not you experience work-related musculoskeletal discomfort, your participation in this study is important. In order to understand the causes of work-related stress and pain, it is important to have the participation of many Radiation Therapists, including those who do and
do not experience discomfort at work. Thank you very much for choosing to participate in this important study.

A subject ID number will be assigned to your questionnaire, so that your name will not be directly linked to your responses. Your email address will not be shared to anyone outside the research team.

This study is being conducted by OSU researchers in the School of Health and Rehabilitation Sciences and the College of Engineering: Dr. Kevin Evans (office phone 614-688-4535) and Dr. Carolyn M. Sommerich (office phone: 614-292-9965). IRB# 2016B0039

1.2. This study is designed for radiation therapists. Your interest in this study is appreciated, but it seems that you do not meet the study inclusion criteria. Have a good day.

1.3. Are you currently registered as a radiation therapist?

Yes
No

1.4. We request that you review a brief consent form. If you are comfortable with the information on that form, from there you can continue on to the questionnaire.

Are you ready to proceed to the informed consent form?

Yes
No

1.5. In order to participate in this study, you will need to provide your consent. Are you ready to proceed to the informed consent form now?

Yes
No
2.1. Demographics

In this part of the questionnaire, you will be asked questions about your demographic characteristics.
Your answers are confidential.

2.2. List your professional credentials (For example: R.T.(R)):

2.3. List job title and clinical area (For example: Radiographer-Fluoroscopy; Radiation Therapist -Clinical; Radiation Therapist-Dosimetry):

2.4. What is your current age?
Less than 20
20-29
30-39
40-49
50 and above

2.5. How many years have you been working as a Radiation Therapist?
Less than 3 years
3-5 years
6-10 years
11-15 years
16-20 years
21 or more years

2.6. Are you a full-time or part-time employee? (If contingent/casual or other, please describe.)

Full-time employee
Part-time employee
Contingent/casual
Other

2.7. Indicate your sex:

Female
Male

2.8. Indicate your height:

Less than 5'
5' to less than 5'2"
5'2" to less than 5'4"
5'4" to less than 5'6"
5'6" to less than 5'8"
5'8" to less than 5'10"
5'10" to less than 6'0"
6'0" to less than 6'2"
6'2" to less than 6'4"
6'4" or taller

2.9. Please provide your normal weight (in pounds):
2.10. Which hand do you consider your dominant hand (e.g., the hand that you would write with)?
Right
Left

2.11. Which leg do you consider your dominant leg (e.g., the leg you would kick a ball with)?
Right
Left

Work Information

3.1. Work Information

In this part of the questionnaire, you will be asked questions about your work environment.
Your answers are confidential.

3.2. What portion of your work is devoted to supervisory or quality control activities rather than completing patient cases?
0-10% of the shift
11-20% of the shift
21-30% of the shift
31-40% of the shift
more than 41% of the shift

3.3. On average, how many radiographic exams or therapy treatments do you perform each day?
3.4. Please estimate the average amount of time that you spend on a typical patient case:

Less than 10 minutes
11-15 minutes
16-20 minutes
21-25 minutes
26-30 minutes
31-45 minutes
more than 45 minutes

3.5. How long is your work shift?

< 8 hours
8-9 hours
9-11 hours
> 12 hours

3.6. Do you take after-hours call?

Yes
No

3.7. How often do you take call (e.g., X times per week)?
3.8. What kinds of breaks occur in your workday on most days? Choose the most common one(s) for you.

Very brief breaks (restroom, water, etc.)
A 10-15 minute break in the first half of my work day
A 10-15 minute break in the second half of my work day
A mid-shift break that is less than 30 minutes long (lunch/dinner/meal break)
A mid-shift break that is at least 30 minutes long (lunch/dinner/meal break)

3.9. Please indicate how many imaging or therapy units are used in your workplace:

<table>
<thead>
<tr>
<th>Number of CT Scanners</th>
<th>Number of Linear Accelerators</th>
<th>Number of other treatment or imaging units</th>
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3.10. What equipment do you use? List all that apply as well as the make and model. If more than 5, select the 5 most commonly used:

3.11. When your department purchases new equipment, are you shown how to use all the features on the system that might make your work easier?

Yes
No
Not sure
N/A
3.12. Who shows you these system features on the radiographic equipment? Check all that apply.

Clinical applications specialist
Sales person
Department supervisor
Fellow staff member
The user's manual
A consultant
Manufacturer website

Other:

N/A

3.13. Please evaluate your work based on the following six areas. Mark on each scale the point which matches your experience at your work. Please pay attention to the wordings at both ends of the scales. Please consider each scale individually.

3.14. In general, how mentally demanding is your work?

Very Low

3.15. In general, how physically demanding is your work?

Very Low

3.16. In general, how hurried or rushed is the pace of your work?

Very Low
3.17. In general, how successful are you in accomplishing what you are asked to do at work?

Failure

3.18. In general, how hard do you have to work to accomplish your level of performance?

Very Low

3.19. In general, how frustrated (insecure, discouraged, irritated, stressed, or annoyed) are you during work?

Very Low

3.20. Do you ever encounter patients who are physically challenging to work with?

Yes

No

3.21. Of all physically challenging patients that you work with, indicate the percentage of each type of patient that you typically encounter (e.g., of all physically challenging patients that I work with, X% are elderly).

Elderly patients

Heavy or obese patients

Physically impaired patients

Patients who are much shorter than me
Your Musculoskeletal Health

4.1. Your Musculoskeletal Health

In this part of the questionnaire, you will be asked questions about your musculoskeletal health for each part of your body.

- For multiple choice questions, please choose the answer(s) that come closest to describing you or your situation.
- Please try to answer all the questions that are presented to you.
- Your answers are confidential.

The following questions will ask you about different body parts. The pictures below show how the body has been divided in the questionnaire. **Limits are not sharply defined and certain parts overlap. You should decide for yourself which part (if any) is or has been affected.**
4.2. Do you experience any **pain** or **discomfort** when performing patient cases?
Yes
No

4.3. The following questions will ask you to describe any **neck** discomfort you have experienced in the **last 12 months**.
4.4. Have you ever been diagnosed with neck osteoarthritis (OA)?

Yes
No

4.5. Have you ever had a bone fusion in your neck?

Yes
No

4.6. During the last 12 months, have you had any discomfort (ache, pain, stiffness, burning, numbness, tingling, or other discomfort) in your neck?

Yes
No

4.7. How often during the last 12 months have you experienced this neck discomfort?

Daily
On most days that I work
A few times a month
A few times a year

4.8. Was your neck discomfort originally caused by a traumatic (sudden) injury outside of work?

Yes
No

4.9. On a scale of 0 to 10, what is the typical intensity of your neck discomfort when you have it?
(Click and drag the slider to the appropriate value. 0 represents the least intensity, 10 represents the highest intensity.)

4.10. Within the last 12 months, has your neck discomfort caused you to see a health care provider, such as doctor, physical therapist, or chiropractor?

Yes
No

4.11. Have you taken medication because of your neck discomfort? (Over the counter or prescription)

Yes
No

4.12. Have you taken sick leave from work due to your neck discomfort?

Yes
No

4.13. When did your neck discomfort begin?

Before I began working as a radiation therapist
After I began working as a radiation therapist

4.14. Has your neck discomfort interfered with your normal activities (on the job or off)?

Yes
4.15. Have you had to change jobs or duties (even temporarily) because of your neck discomfort?
Yes
No

4.16. Do activities at work make your neck discomfort worse?
Yes
No

4.17. Do activities off-the-job make your neck discomfort worse?
Yes
No

4.18. Have you had any neck discomfort during the past 7 days?
Yes
No

4.19. The next page contains questions about your shoulders.

4.20.
Shoulder

The following questions will ask you to describe any shoulder discomfort you have experienced in the last 12 months.

4.21. Have you ever been diagnosed with shoulder osteoarthritis (OA)?
- Yes, right side
- Yes, left side
- Yes, both sides
- No

4.22. Have you ever had a shoulder replacement?
- Yes, right side
- Yes, left side
- Yes, both sides
- No

4.23. During the last 12 months, have you had any discomfort (ache, pain, stiffness, burning, numbness, tingling, or other discomfort) in your shoulders?
- Yes
- No

4.24. On which side have you experienced this shoulder discomfort?
4.25. Is the type of discomfort (e.g., ache, pain, stiffness, burning, numbness, tingling, or other discomfort) that you experience the same in both shoulders?

Yes
No

4.26. How often during the last 12 months have you experienced this shoulder discomfort?

Daily
On most days that I work
A few times a month
A few times a year

4.27. Was your shoulder discomfort originally caused by a traumatic (sudden) injury outside of work?

Yes
No

4.28. On a scale of 0 to 10, what is the typical intensity of your shoulder discomfort when you have it?

(Click and drag the slider to the appropriate value. 0 represents the least intensity, 10 represents the highest intensity.)
4.29. Within the last 12 months, has your shoulder discomfort caused you to see a health care provider, such as doctor, physical therapist, or chiropractor?

Yes
No

4.30. Have you taken medication because of your shoulder discomfort? (Over the counter or prescription)

Yes
No

4.31. Have you taken sick leave from work due to your shoulder discomfort?

Yes
No

4.32. When did your shoulder discomfort begin?

Before I began working as a radiation therapist
After I began working as a radiation therapist

4.33. Has your shoulder discomfort interfered with your normal activities (on the job or off)?

Yes
No
4.34. Have you had to change jobs or duties (even temporarily) because of your shoulder discomfort?
Yes
No

4.35. Do activities at work make your shoulder discomfort worse?
Yes
No

4.36. Do activities off-the-job make your shoulder discomfort worse?
Yes
No

4.37. Have you had any shoulder discomfort during the past 7 days?
Yes
No

4.38. How often during the last 12 months have you experienced this shoulder discomfort on the right side?
Daily
On most days that I work
A few times a month
A few times a year

4.39. Was your shoulder discomfort on the right side originally caused by a traumatic (sudden) injury outside of work?
Yes
4.40. On a scale of 0 to 10, what is the **typical intensity** of your **right shoulder discomfort** when you have it?

(Click and drag the slider to the appropriate value. 0 represents the least intensity, 10 represents the highest intensity.)

4.41. Within the last **12 months**, has your **right shoulder discomfort** caused you to see a health care provider, such as doctor, physical therapist, or chiropractor?

Yes
No

4.42. Have you taken medication because of your **right shoulder discomfort**? (Over the counter or prescription)

Yes
No

4.43. Have you taken sick leave from work due to your **right shoulder discomfort**?

Yes
No

4.44. When did your **right shoulder discomfort** begin?

Before I began working as a radiation therapist
After I began working as a radiation therapist

4.45. Has your right shoulder discomfort interfered with your normal activities (on the job or off)?

Yes
No

4.46. Have you had to change jobs or duties (even temporarily) because of your right shoulder discomfort?

Yes
No

4.47. Do activities at work make your right shoulder discomfort worse?

Yes
No

4.48. Do activities off-the-job make your right shoulder discomfort worse?

Yes
No

4.49. Have you had any right shoulder discomfort during the past 7 days?

Yes
No

4.50. How often during the last 12 months have you experienced this shoulder discomfort on the left side?

Daily
On most days that I work
A few times a month
A few times a year

4.51.
Was your shoulder discomfort on the left side originally caused by a traumatic (sudden) injury outside of work?

Yes
No

4.52. On a scale of 0 to 10, what is the typical intensity of your left shoulder discomfort when you have it?

(Click and drag the slider to the appropriate value. 0 represents the least intensity, 10 represents the highest intensity.)

Intensity of shoulder discomfort

0 1 2 3 4 5 6 7 8 9 10

4.53. Within the last 12 months, has your left shoulder discomfort caused you to see a health care provider, such as doctor, physical therapist, or chiropractor?

Yes
No

4.54. Have you taken medication because of your left shoulder discomfort? (Over the counter or prescription)

Yes
No
4.55. Have you taken sick leave from work due to your **left shoulder discomfort**?

Yes
No

4.56. When did your **left shoulder discomfort** begin?

Before I began working as a radiation therapist
After I began working as a radiation therapist

4.57. Has your **left shoulder discomfort** interfered with your normal activities (on the job or off)?

Yes
No

4.58. Have you had to change jobs or duties (even temporarily) because of your **left shoulder discomfort**?

Yes
No

4.59. Do activities at work make your **left shoulder discomfort** worse?

Yes
No

4.60. Do activities off-the-job make your **left shoulder discomfort** worse?

Yes
No

4.61. Have you had **any left shoulder discomfort** during the **past 7 days**?
4.62. The next page contains questions about your elbows/forearms.

4.63. The following questions will ask you to describe any elbow/forearm discomfort you have experienced in the last 12 months.

4.64. Have you ever been diagnosed with elbow/forearm osteoarthritis (OA)?
   Yes, right side
   Yes, left side
   Yes, both sides
   No

4.65. Have you ever had an elbow replacement or bone fusion?
   Yes, right side
   Yes, left side
   Yes, both sides
   No

4.66. During the last 12 months, have you had any discomfort (e.g., ache, pain, stiffness, burning, numbness, tingling, or other discomfort) in
your elbows/forearms?
Yes
No

4.67. On which side have you experienced this elbow/forearm discomfort?
Right
Left
Both

4.68. Is the type of discomfort (e.g., ache, pain, stiffness, burning, numbness, tingling, or other discomfort) that you experience the same in both elbows/forearms?
Yes
No

4.69. How often during the last 12 months have you experienced this elbow/forearm discomfort?
Daily
On most days that I work
A few times a month
A few times a year

4.70. Was your elbow/forearm discomfort originally caused by a traumatic (sudden) injury outside of work?
Yes
No
4.71. On a scale of 0 to 10, what is the typical intensity of your **elbow/forearm discomfort** when you have it?

(Click and drag the slider to the appropriate value. 0 represents the least intensity, 10 represents the highest intensity.)

<table>
<thead>
<tr>
<th>Intensity of elbow/forearm discomfort</th>
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<tbody>
<tr>
<td>0 1 2 3 4 5 6 7 8 9 10</td>
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</table>

4.72. Within the last **12 months**, has your **elbow/forearm discomfort** caused you to see a health care provider, such as doctor, physical therapist, or chiropractor?

Yes
No

4.73. Have you taken medication because of your **elbow/forearm discomfort**? (Over the counter or prescription)

Yes
No

4.74. Have you taken sick leave from work due to your **elbow/forearm discomfort**?

Yes
No

4.75. When did your **elbow/forearm discomfort** begin?

Before I began working as a radiation therapist
After I began working as a radiation therapist
4.76. Has your **elbow/forearm discomfort** interfered with your normal activities (on the job or off)?

Yes
No

4.77. Have you had to change jobs or duties (even temporarily) because of your **elbow/forearm discomfort**?

Yes
No

4.78. Do activities at work make your **elbow/forearm discomfort** worse?

Yes
No

4.79. Do activities off-the-job make your **elbow/forearm discomfort** worse?

Yes
No

4.80. Have you had any **elbow/forearm discomfort** during the **past 7 days**?

Yes
No

4.81. How often during the **last 12 months** have you experienced this **right elbow/forearm discomfort**?

Daily
On most days that I work
A few times a month
A few times a year

4.82. Was your right elbow/forearm discomfort originally caused by a traumatic (sudden) injury outside of work?
Yes
No

4.83. On a scale of 0 to 10, what is the typical intensity of your right elbow/forearm discomfort when you have it?

(Click and drag the slider to the appropriate value. 0 represents the least intensity, 10 represents the highest intensity.)

0 1 2 3 4 5 6 7 8 9 10

Intensity of elbow/forearm discomfort

4.84. Within the last 12 months, has your right elbow/forearm discomfort caused you to see a health care provider, such as doctor, physical therapist, or chiropractor?
Yes
No

4.85. Have you taken medication because of your right elbow/forearm discomfort? (Over the counter or prescription)
Yes
No
4.86. Have you taken sick leave from work due to your **right elbow/forearm discomfort**?

Yes
No

4.87. When did your **right elbow/forearm discomfort** begin?

Before I began working as a radiation therapist
After I began working as a radiation therapist

4.88. Has your **right elbow/forearm discomfort** interfered with your normal activities (on the job or off)?

Yes
No

4.89. Have you had to change jobs or duties (even temporarily) because of your **right elbow/forearm discomfort**?

Yes
No

4.90. Do activities at work make your **right elbow/forearm discomfort** worse?

Yes
No

4.91. Do activities off-the-job make your **right elbow/forearm discomfort** worse?

Yes
No
4.92. Have you had any right elbow/forearm discomfort during the past 7 days?

Yes
No

4.93. How often during the last 12 months have you experienced this left elbow/forearm discomfort?

Daily
On most days that I work
A few times a month
A few times a year

4.94. Was your left elbow/forearm discomfort originally caused by a traumatic (sudden) injury outside of work?

Yes
No

4.95. On a scale of 0 to 10, what is the typical intensity of your left elbow/forearm discomfort when you have it?

(Click and drag the slider to the appropriate value. 0 represents the least intensity, 10 represents the highest intensity.)

0 1 2 3 4 5 6 7 8 9 10

Intensity of elbow/forearm discomfort

4.96. Within the last 12 months, has your left elbow/forearm discomfort caused you to see a health care provider, such as doctor, physical therapist,
or chiropractor?

Yes
No

4.97. Have you taken medication because of your left elbow/forearm discomfort? (Over the counter or prescription)

Yes
No

4.98. Have you taken sick leave from work due to your left elbow/forearm discomfort?

Yes
No

4.99. When did your left elbow/forearm discomfort begin?

Before I began working as a radiation therapist
After I began working as a radiation therapist

4.100. Has your left elbow/forearm discomfort interfered with your normal activities (on the job or off)?

Yes
No

4.101. Have you had to change jobs or duties (even temporarily) because of your left elbow/forearm discomfort?

Yes
No
4.102. Do activities at work make your left elbow/forearm discomfort worse?

Yes
No

4.103. Do activities off-the-job make your left elbow/forearm discomfort worse?

Yes
No

4.104. Have you had any left elbow/forearm discomfort during the past 7 days?

Yes
No

4.105. The next page contains questions about your wrists/hands.

4.106. Wrist/Hand

The following questions will ask you to describe any wrist/hand discomfort you have experienced in the last 12 months.

4.107. Have you ever been diagnosed with wrist/hand osteoarthritis (OA)?

Yes, right side
4.108. Have you ever had a wrist replacement or bone fusion?

Yes, right side
Yes, left side
Yes, both sides
No

4.109. During the last 12 months, have you had any discomfort (e.g., ache, pain, stiffness, burning, numbness, tingling, or other discomfort) in your wrists/hands?

Yes
No

4.110. On which side have you experienced this wrist/hand discomfort?

Right
Left
Both

4.111. Is the type of discomfort (e.g., ache, pain, stiffness, burning, numbness, tingling, or other discomfort) that you experience the same in both wrists/hands?

Yes
No

4.112. How often during the last 12 months have you experienced this wrist/hand discomfort?
Daily
On most days that I work
A few times a month
A few times a year

4.113. Was your wrist/hand discomfort originally caused by a traumatic (sudden) injury outside of work?
Yes
No

4.114. On a scale of 0 to 10, what is the typical intensity of your wrist/hand discomfort when you have it?

(Click and drag the slider to the appropriate value. 0 represents the least intensity, 10 represents the highest intensity.)

0 1 2 3 4 5 6 7 8 9 10

intensity of wrist/hand discomfort

4.115. Within the last 12 months, has your wrist/hand discomfort caused you to see a health care provider, such as doctor, physical therapist, or chiropractor?
Yes
No

4.116. Have you taken medication because of your wrist/hand discomfort?(Over the counter or prescription)
Yes
No
4.117. Have you taken sick leave from work due to your **wrist/hand discomfort**?

Yes  
No  

4.118. When did your **wrist/hand discomfort** begin?

Before I began working as a radiation therapist  
After I began working as a radiation therapist  

4.119. Has your **wrist/hand discomfort** interfered with your normal activities (on the job or off)?

Yes  
No  

4.120. Have you had to change jobs or duties (even temporarily) because of your **wrist/hand discomfort**?

Yes  
No  

4.121. Do activities at work make your **wrist/hand discomfort** worse?

Yes  
No  

4.122. Do activities off-the-job make your **wrist/hand discomfort** worse?

Yes  
No
4.123. Have you had any **wrist/hand discomfort** during the past 7 days?
Yes
No

4.124. How often during the last 12 months have you experienced this **right wrist/hand discomfort**?
Daily
On most days that I work
A few times a month
A few times a year

4.125. Was your **right wrist/hand discomfort** originally caused by a traumatic (sudden) injury outside of work?
Yes
No

4.126. On a scale of 0 to 10, what is the **typical intensity** of your **right wrist/hand discomfort** when you have it?

(Click and drag the slider to the appropriate value. 0 represents the least intensity, 10 represents the highest intensity.)

0 1 2 3 4 5 6 7 8 9 10

4.127. Within the last 12 months, has your **right wrist/hand discomfort** caused you to see a health care provider, such as doctor, physical therapist, or chiropractor?
4.128. Have you taken medication because of your right wrist/hand discomfort? (Over the counter or prescription)
Yes
No

4.129. Have you taken sick leave from work due to your right wrist/hand discomfort?
Yes
No

4.130. When did your right wrist/hand discomfort begin?
Before I began working as a radiation therapist
After I began working as a radiation therapist

4.131. Has your right wrist/hand discomfort interfered with your normal activities (on the job or off)?
Yes
No

4.132. Have you had to change jobs or duties (even temporarily) because of your right wrist/hand discomfort?
Yes
No

4.133. Do activities at work make your right wrist/hand discomfort worse?
4.134. Do activities off-the-job make your right wrist/hand discomfort worse?

Yes  No

4.135. Have you had any right wrist/hand discomfort during the past 7 days?

Yes  No

4.136. How often during the last 12 months have you experienced this left wrist/hand discomfort?

Daily
On most days that I work
A few times a month
A few times a year

4.137. Was your left wrist/hand discomfort originally caused by a traumatic (sudden) injury outside of work?

Yes  No

4.138. On a scale of 0 to 10, what is the typical intensity of your left wrist/hand discomfort when you have it?
(Click and drag the slider to the appropriate value. 0 represents the least intensity, 10 represents the highest intensity.)

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<tbody>
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<td>intensity of wrist/hand discomfort</td>
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</table>

4.139. Within the last 12 months, has your left wrist/hand discomfort caused you to see a health care provider, such as doctor, physical therapist, or chiropractor?

Yes
No

4.140. Have you taken medication because of your left wrist/hand discomfort? (Over the counter or prescription)

Yes
No

4.141. Have you taken sick leave from work due to your left wrist/hand discomfort?

Yes
No

4.142. When did your left wrist/hand discomfort begin?

Before I began working as a radiation therapist
After I began working as a radiation therapist

4.143. Has your left wrist/hand discomfort interfered with your normal activities (on the job or off)?
4.144. Have you had to change jobs or duties (even temporarily) because of your left wrist/hand discomfort?

Yes
No

4.145. Do activities at work make your left wrist/hand discomfort worse?

Yes
No

4.146. Do activities off-the-job make your left wrist/hand discomfort worse?

Yes
No

4.147. Have you had any left wrist/hand discomfort during the past 7 days?

Yes
No

4.148. The next page contains questions about your upper back.

4.149.
Upper back

The following questions will ask you to describe any upper back discomfort you have experienced in the last 12 months.

4.150. Have you ever been diagnosed with osteoarthritis (OA) in your upper back?
Yes
No

4.151. Have you ever had a bone fusion in your upper back?
Yes
No

4.152. During the last 12 months, have you had any discomfort (e.g., ache, pain, stiffness, burning, numbness, tingling, or other discomfort) in your upper back?
Yes
No

4.153. How often during the last 12 months have you experienced this upper back discomfort?
Daily
On most days that I work
A few times a month
A few times a year

4.154. Was your upper back discomfort originally caused by a traumatic (sudden) injury outside of work?
Yes
No

4.155. On a scale of 0 to 10, what is the typical intensity of your upper back discomfort when you have it?

(Click and drag the slider to the appropriate value. 0 represents the least intensity, 10 represents the highest intensity.)

Intensity of upper back discomfort

4.156. Within the last 12 months, has your upper back discomfort caused you to see a health care provider, such as doctor, physical therapist, or chiropractor?
Yes
No

4.157. Have you taken medication because of your upper back discomfort? (Over the counter or prescription)
Yes
No

4.158. Have you taken sick leave from work due to your upper back discomfort?
4.159. When did your upper back discomfort begin?

Before I began working as a radiation therapist
After I began working as a radiation therapist

4.160. Has your upper back discomfort interfered with your normal activities (on the job or off)?

Yes
No

4.161. Have you had to change jobs or duties (even temporarily) because of your upper back discomfort?

Yes
No

4.162. Do activities at work make your upper back discomfort worse?

Yes
No

4.163. Do activities off-the-job make your upper back discomfort worse?

Yes
No

4.164. Have you had any upper back discomfort during the past 7 days?

Yes
No
4.165. The next page contains questions about your lower back.

4.166. Lower back

The following questions will ask you to describe any lower back discomfort you have experienced in the last 12 months.

4.167. Have you ever been diagnosed with osteoarthritis (OA) in your lower back?
   Yes
   No

4.168. Have you ever had a bone fusion in your lower back?
   Yes
   No

4.169. During the last 12 months, have you had any discomfort (e.g., ache, pain, stiffness, burning, numbness, tingling, or other discomfort) in your lower back?
   Yes
   No
4.170. How often during the last 12 months have you experienced this lower back discomfort?

- Daily
- On most days that I work
- A few times a month
- A few times a year

4.171. Was your lower back discomfort originally caused by a traumatic (sudden) injury outside of work?

- Yes
- No

4.172. On a scale of 0 to 10, what is the typical intensity of your lower back discomfort when you have it?

(Click and drag the slider to the appropriate value. 0 represents the least intensity, 10 represents the highest intensity.)

Intensity of lower back discomfort

4.173. Within the last 12 months, has your lower back discomfort caused you to see a health care provider, such as doctor, physical therapist, or chiropractor?

- Yes
- No

4.174. Have you taken medication because of your lower back discomfort? (Over the counter or prescription)
4.175. Have you taken sick leave from work due to your lower back discomfort?

Yes
No

4.176. When did your lower back discomfort begin?

Before I began working as a radiation therapist
After I began working as a radiation therapist

4.177. Has your lower back discomfort interfered with your normal activities (on the job or off)?

Yes
No

4.178. Have you had to change jobs or duties (even temporarily) because of your lower back discomfort?

Yes
No

4.179. Do activities at work make your lower back discomfort worse?

Yes
No

4.180. Do activities off-the-job make your lower back discomfort worse?

Yes
4.181. Have you had any lower back discomfort during the past 7 days?
Yes
No

4.182. The next page contains questions about your hips/thighs.

4.183. Hip/Thigh

The following questions will ask you to describe any hip/thigh issues and discomfort you have experienced.

4.184. Have you ever been diagnosed with hip osteoarthritis (OA)?
Yes, right side
Yes, left side
Yes, both sides
No

4.185. Have you ever had a hip replacement?
Yes, right side
Yes, left side
Yes, both sides
No
4.186. Have you ever been diagnosed with any musculoskeletal disorder other than hip osteoarthritis in your hips/thighs?

Yes, right side
Yes, left side
Yes, both sides
No

4.187. What was the diagnosis?


4.188. What year did you receive it?


4.189. During the last 12 months, have you had any discomfort (e.g., ache, pain, stiffness, burning, numbness, tingling, or other discomfort) in your hips/thighs?

Yes
No

4.190. On which side have you experienced this hip/thigh discomfort?

Right
Left
Both

4.191. Is the type of discomfort (e.g., ache, pain, stiffness, burning, numbness, tingling, or other discomfort) that you experience the same in both hips/thighs?
4.192. How often during the last 12 months have you experienced this hip/thigh discomfort?

- Daily
- On most days that I work
- A few times a month
- A few times a year

4.193. Was your hip/thigh discomfort originally caused by a traumatic (sudden) injury outside of work?

- Yes
- No

4.194. On a scale of 0 to 10, what is the typical intensity of your hip/thigh discomfort when you have it?

(Click and drag the slider to the appropriate value. 0 represents the least intensity, 10 represents the highest intensity.)

Intensity of hip/thigh discomfort

0 1 2 3 4 5 6 7 8 9 10

4.195. Within the last 12 months, has your hip/thigh discomfort caused you to see a health care provider, such as doctor, physical therapist, or chiropractor?

- Yes
4.196. Have you taken medication because of your hip/thigh discomfort? (Over the counter or prescription)

Yes
No

4.197. Have you taken sick leave from work due to your hip/thigh discomfort?

Yes
No

4.198. When did your hip/thigh discomfort begin?

Before I began working as a radiation therapist
After I began working as a radiation therapist

4.199. Has your hip/thigh discomfort interfered with your normal activities (on the job or off)?

Yes
No

4.200. Have you had to change jobs or duties (even temporarily) because of your hip/thigh discomfort?

Yes
No

4.201. Do activities at work make your hip/thigh discomfort worse?

Yes
4.202. Do activities off-the-job make your **hip/thigh discomfort** worse?

Yes

No

4.203. Have you had any **hip/thigh discomfort** during the past 7 days?

Yes

No

4.204. How often during the last 12 months have you experienced this **right hip/thigh discomfort**?

Daily

On most days that I work

A few times a month

A few times a year

4.205. Was your **right hip/thigh discomfort** originally caused by a traumatic (sudden) injury outside of work?

Yes

No

4.206. On a scale of 0 to 10, what is the **typical intensity** of your **right hip/thigh discomfort** when you have it?

(Click and drag the slider to the appropriate value. 0 represents the least intensity, 10 represents the highest intensity.)

0 1 2 3 4 5 6 7 8 9 10
4.207. Within the last 12 months, has your right hip/thigh discomfort caused you to see a health care provider, such as doctor, physical therapist, or chiropractor?

Yes
No

4.208. Have you taken medication because of your right hip/thigh discomfort? (Over the counter or prescription)

Yes
No

4.209. Have you taken sick leave from work due to your right hip/thigh discomfort?

Yes
No

4.210. When did your right hip/thigh discomfort begin?

Before I began working as a radiation therapist
After I began working as a radiation therapist

4.211. Has your right hip/thigh discomfort interfered with your normal activities (on the job or off)?

Yes
No
4.212. Have you had to change jobs or duties (even temporarily) because of your right hip/thigh discomfort?
Yes
No

4.213. Do activities at work make your right hip/thigh discomfort worse?
Yes
No

4.214. Do activities off-the-job make your right hip/thigh discomfort worse?
Yes
No

4.215. Have you had any right hip/thigh discomfort during the past 7 days?
Yes
No

4.216. How often during the last 12 months have you experienced this left hip/thigh discomfort?
Daily
On most days that I work
A few times a month
A few times a year

4.217. Was your left hip/thigh discomfort originally caused by a traumatic (sudden) injury outside of work?
4.218. On a scale of 0 to 10, what is the typical intensity of your left hip/thigh discomfort when you have it?

(Click and drag the slider to the appropriate value. 0 represents the least intensity, 10 represents the highest intensity.)

0 1 2 3 4 5 6 7 8 9 10

Intensity of hip/thigh discomfort

4.219. Within the last 12 months, has your left hip/thigh discomfort caused you to see a health care provider, such as doctor, physical therapist, or chiropractor?

Yes
No

4.220. Have you taken medication because of your left hip/thigh discomfort? (Over the counter or prescription)

Yes
No

4.221. Have you taken sick leave from work due to your left hip/thigh discomfort?

Yes
No

4.222. When did your left hip/thigh discomfort begin?
Before I began working as a radiation therapist
After I began working as a radiation therapist

4.223. Has your left hip/thigh discomfort interfered with your normal activities (on the job or off)?
Yes
No

4.224. Have you had to change jobs or duties (even temporarily) because of your left hip/thigh discomfort?
Yes
No

4.225. Do activities at work make your left hip/thigh discomfort worse?
Yes
No

4.226. Do activities off-the-job make your left hip/thigh discomfort worse?
Yes
No

4.227. Have you had any left hip/thigh discomfort during the past 7 days?
Yes
No

4.228. The next page contains questions about your knees.
4.229. Knee

The following questions will ask you to describe any knee issues and discomfort you have experienced.

4.230. Have you ever been diagnosed with knee osteoarthritis (OA)?

Yes, right side
Yes, left side
Yes, both sides
No

4.231. Have you ever had a knee replacement?

Yes, right side
Yes, left side
Yes, both sides
No

4.232. Have you ever been diagnosed with any musculoskeletal disorder other than knee osteoarthritis in your knees?

Yes, right side
Yes, left side
Yes, both sides
No
4.233. What was the diagnosis?

4.234. What year did you receive it?

4.235. During the last 12 months, have you had any discomfort (e.g., ache, pain, stiffness, burning, numbness, tingling, or other discomfort) in your knees?

Yes
No

4.236. On which side have you experienced this knee discomfort?

Right
Left
Both

4.237. Is the type of discomfort (e.g., ache, pain, stiffness, burning, numbness, tingling, or other discomfort) that you experience the same in both knees?

Yes
No

4.238. How often during the last 12 months have you experienced this knee discomfort?

Daily
On most days that I work
A few times a month
A few times a year

4.239.
Was your knee discomfort originally caused by a traumatic (sudden) injury outside of work?
Yes
No

4.240. On a scale of 0 to 10, what is the typical intensity of your knee discomfort when you have it?

(Click and drag the slider to the appropriate value. 0 represents the least intensity, 10 represents the highest intensity.)

Intensity of knee discomfort

4.241. Within the last 12 months, has your knee discomfort caused you to see a health care provider, such as doctor, physical therapist, or chiropractor?
Yes
No

4.242. Have you taken medication because of your knee discomfort? (Over the counter or prescription)
Yes
No

4.243. Have you taken sick leave from work due to your knee discomfort?
4.244. When did your knee discomfort begin?

Before I began working as a radiation therapist
After I began working as a radiation therapist

4.245. Has your knee discomfort interfered with your normal activities (on the job or off)?

Yes
No

4.246. Have you had to change jobs or duties (even temporarily) because of your knee discomfort?

Yes
No

4.247. Do activities at work make your knee discomfort worse?

Yes
No

4.248. Do activities off-the-job make your knee discomfort worse?

Yes
No

4.249. Have you had any knee discomfort during the past 7 days?

Yes
No
4.250. How often during the last 12 months have you experienced this right knee discomfort?

Daily
On most days that I work
A few times a month
A few times a year

4.251. Was your right knee discomfort originally caused by a traumatic (sudden) injury outside of work?

Yes
No

4.252. On a scale of 0 to 10, what is the typical intensity of your right knee discomfort when you have it?

(Click and drag the slider to the appropriate value. 0 represents the least intensity, 10 represents the highest intensity.)

Intensity of knee discomfort

4.253. Within the last 12 months, has your right knee discomfort caused you to see a health care provider, such as doctor, physical therapist, or chiropractor?

Yes
No
4.254. Have you taken medication because of your right knee discomfort? (Over the counter or prescription)

Yes  
No

4.255. Have you taken sick leave from work due to your right knee discomfort?

Yes  
No

4.256. When did your right knee discomfort begin?

Before I began working as a radiation therapist  
After I began working as a radiation therapist

4.257. Has your right knee discomfort interfered with your normal activities (on the job or off)?

Yes  
No

4.258. Have you had to change jobs or duties (even temporarily) because of your right knee discomfort?

Yes  
No

4.259. Do activities at work make your right knee discomfort worse?

Yes  
No
4.260. Do activities off-the-job make your **right knee discomfort** worse?

Yes
No

4.261. Have you had **any right knee discomfort** during the **past 7 days**?

Yes
No

4.262. How often during the **last 12 months** have you experienced this **left knee discomfort**?

Daily
On most days that I work
A few times a month
A few times a year

4.263. Was your **left knee discomfort** originally caused by a traumatic (sudden) injury outside of work?

Yes
No

4.264. On a scale of 0 to 10, what is the **typical intensity of your left knee discomfort** when you have it?

(Click and drag the slider to the appropriate value. 0 represents the least intensity, 10 represents the highest intensity.)
4.265. Within the last 12 months, has your left knee discomfort caused you to see a health care provider, such as doctor, physical therapist, or chiropractor?

Yes
No

4.266. Have you taken medication because of your left knee discomfort? (Over the counter or prescription)

Yes
No

4.267. Have you taken sick leave from work due to your left knee discomfort?

Yes
No

4.268. When did your left knee discomfort begin?

Before I began working as a radiation therapist
After I began working as a radiation therapist

4.269. Has your left knee discomfort interfered with your normal activities (on the job or off)?

Yes
No

4.270. Have you had to change jobs or duties (even temporarily) because of your left knee discomfort?

Yes
4.271. Do activities at work make your left knee discomfort worse?
Yes
No

4.272. Do activities off-the-job make your left knee discomfort worse?
Yes
No

4.273. Have you had any left knee discomfort during the past 7 days?
Yes
No

4.274. The next page contains questions about your ankles/feet.

4.275. The following questions will ask you to describe any ankle/foot issues and discomfort you have experienced.

4.276. Have you ever been diagnosed with ankle/foot osteoarthritis (OA)?
Yes, right side
4.277. Have you ever had an ankle replacement or bone fusion?
Yes, right side
Yes, left side
Yes, both sides
No

4.278. Have you ever been diagnosed with any musculoskeletal disorders in your ankles/feet?
Yes, right side
Yes, left side
Yes, both sides
No

4.279. What was the diagnosis?

4.280. What year did you receive it?

4.281. During the last 12 months, have you had any discomfort (e.g., ache, pain, stiffness, burning, numbness, tingling, or other discomfort) in your ankles/feet?
Yes
No
4.282. On which side have you experienced this ankle/foot discomfort?
Right
Left
Both

4.283. Is the type of discomfort (e.g., ache, pain, stiffness, burning, numbness, tingling, or other discomfort) that you experience the same in both ankles/feet?
Yes
No

4.284. How often during the last 12 months have you experienced this ankle/foot discomfort?
Daily
On most days that I work
A few times a month
A few times a year

4.285. Was your ankle/foot discomfort originally caused by a traumatic (sudden) injury outside of work?
Yes
No

4.286. On a scale of 0 to 10, what is the typical intensity of your ankle/foot discomfort when you have it?

(Click and drag the slider to the appropriate value. 0 represents the least intensity, 10 represents the highest intensity.)
4.287. Within the last 12 months, has your ankle/foot discomfort caused you to see a health care provider, such as doctor, physical therapist, or chiropractor?

Yes

No

4.288. Have you taken medication because of your ankle/foot discomfort? (Over the counter or prescription)

Yes

No

4.289. Have you taken sick leave from work due to your ankle/foot discomfort?

Yes

No

4.290. When did your ankle/foot discomfort begin?

Before I began working as a radiation therapist

After I began working as a radiation therapist

4.291. Has your ankle/foot discomfort interfered with your normal activities (on the job or off)?

Yes

No
4.292. Have you had to change jobs or duties (even temporarily) because of your **ankle/foot discomfort**?

Yes  
No  

4.293. Do activities at work make your **ankle/foot discomfort** worse?

Yes  
No  

4.294. Do activities off-the-job make your **ankle/foot discomfort** worse?

Yes  
No  

4.295. Have you had **any ankle/foot discomfort** during the **past 7 days**?

Yes  
No  

4.296. How often during the **last 12 months** have you experienced this **right ankle/foot discomfort**?

Daily  
On most days that I work  
A few times a month  
A few times a year  

4.297. 
Was your **right ankle/foot discomfort** originally caused by a traumatic (sudden) injury outside of work?

Yes
4.298. On a scale of 0 to 10, what is the typical intensity of your right ankle/foot discomfort when you have it?

(Click and drag the slider to the appropriate value. 0 represents the least intensity, 10 represents the highest intensity.)

![Intensity slider]

4.299. Within the last 12 months, has your right ankle/foot discomfort caused you to see a health care provider, such as doctor, physical therapist, or chiropractor?

Yes
No

4.300. Have you taken medication because of your right ankle/foot discomfort? (Over the counter or prescription)

Yes
No

4.301. Have you taken sick leave from work due to your right ankle/foot discomfort?

Yes
No

4.302. When did your right ankle/foot discomfort begin?

Before I began working as a radiation therapist
After I began working as a radiation therapist

4.303. Has your right ankle/foot discomfort interfered with your normal activities (on the job or off)?
Yes  No

4.304. Have you had to change jobs or duties (even temporarily) because of your right ankle/foot discomfort?
Yes  No

4.305. Do activities at work make your right ankle/foot discomfort worse?
Yes  No

4.306. Do activities off-the-job make your right ankle/foot discomfort worse?
Yes  No

4.307. Have you had any right ankle/foot discomfort during the past 7 days?
Yes  No

4.308. How often during the last 12 months have you experienced this left ankle/foot discomfort?
Daily
On most days that I work
A few times a month
A few times a year

4.309.
Was your left ankle/foot discomfort originally caused by a traumatic (sudden) injury outside of work?
Yes
No

4.310. On a scale of 0 to 10, what is the typical intensity of your left ankle/foot discomfort when you have it?

(Click and drag the slider to the appropriate value. 0 represents the least intensity, 10 represents the highest intensity.)

Intensity of ankle/foot discomfort

0  1  2  3  4  5  6  7  8  9  10

4.311. Within the last 12 months, has your left ankle/foot discomfort caused you to see a health care provider, such as doctor, physical therapist, or chiropractor?
Yes
No

4.312. Have you taken medication because of your left ankle/foot discomfort? (Over the counter or prescription)
Yes
No
4.313. Have you taken sick leave from work due to your left ankle/foot discomfort?
Yes
No

4.314. When did your left ankle/foot discomfort begin?
Before I began working as a radiation therapist
After I began working as a radiation therapist

4.315. Has your left ankle/foot discomfort interfered with your normal activities (on the job or off)?
Yes
No

4.316. Have you had to change jobs or duties (even temporarily) because of your left ankle/foot discomfort?
Yes
No

4.317. Do activities at work make your left ankle/foot discomfort worse?
Yes
No

4.318. Do activities off-the-job make your left ankle/foot discomfort worse?
Yes
No
4.319. Have you had any **left ankle/foot discomfort** during the past 7 days?

- Yes
- No

4.320. **Work-related Injuries**

In this part of the questionnaire, you will be asked questions about work-related injuries.

For multiple choice questions, please choose the answer(s) that come closest to describing you or your situation.

Your answers are confidential.

4.321. If you have experienced pain while working, have you reported this to your administrator or the occupational health department?

- Yes
- No
- N/A

4.322. Have you received a medical diagnosis for the type of disorder you have?

- Yes
- No

4.323. Were you told that it was related to your occupation?

- Yes
- No
4.324. What type of treatment or treatments have you tried? (Check all that apply.)

- Total rest
- Limited duty
- Anti-inflammatory medication
- Physical therapy
- Occupational therapy
- Surgery
- Acupuncture
- Massage therapy
- Braces/Splints
- Pre-work stretching/Exercise
- Self-medications
- Other

N/A

4.325. Did you benefit from the prescribed treatment?

- Yes
- No
- N/A

4.326. Which treatments were beneficial? (Check all that apply.)

- Total rest
- Limited duty
- Anti-inflammatory medication
- Physical therapy
- Occupational therapy
- Surgery
4.327. In your opinion, what are the reasons that cause you to have pain or discomfort when performing exams? Rate the following activities by the degree to which they **aggravate your pain and discomfort**.

(1 = Does not aggravate your pain; 4 = Greatly aggravates your pain; select N/A if the situation does not apply.)

<table>
<thead>
<tr>
<th>Activity</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td>Manipulating the imaging equipment</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Positioning patients</td>
<td></td>
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</tr>
<tr>
<td>Transferring patients to the table/cart</td>
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<tr>
<td>Lifting and assisting patients</td>
<td></td>
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<tr>
<td>Standing</td>
<td></td>
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<tr>
<td>Sustained twisting of the neck and trunk</td>
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<td></td>
</tr>
<tr>
<td>Keyboarding to enter patient data</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

4.328. Have you ever taken time off work because of your pain and discomfort?

Yes

No
4.329. How many days did you take off?

1-3 days
4-5 days
6-10 days
More than 10 days

4.330. Did you take this time off as______________________?

Vacation
Sick leave
Disability
Other

4.331. How did your employer distribute your work load while you were off?

Additional cases were assigned to other staff therapists
Number of patients scheduled each day was reduced
A part-time therapist filled in for part of each day
An agency therapist was hired for the time I was off
A per diem therapist was used to cover the work
Other

Psychosocial Aspects

5.1. Psychosocial Aspects

In this part of the questionnaire, you will be asked questions related to the psychosocial aspects of your work environment.

For each question please choose ONE response, the one that comes closest to describing you or your situation.
5.2. **The following questions will ask about work pressure.**

5.3. How often do you feel frustrated/overwhelmed/stressed by the number of patients that are assigned to you?

Never
Occasionally
Often
Always

5.4. How often do you feel frustrated/overwhelmed/stressed by the amount of care that is required/demanded by the patients that are assigned to you?

Never
Occasionally
Often
Always

5.5. How often do you feel frustrated/overwhelmed/stressed by the decision making you have to do based on the patients that are assigned to you?

Never
Occasionally
Often
Always

5.6. How often do you feel frustrated/overwhelmed/stressed by your work schedule (e.g., number of hours, overtime, changes to schedule, shift-related concerns, etc.)?

Never
5.7. How often do you feel frustrated/overwhelmed/stressed by understaffing in your department or elsewhere in the hospital?

Never
Occasionally
Often
Always

5.8. How often are you able to mentally relax once you have finished working?

Never
Occasionally
Often
Always

5.9. The following questions will ask about job control.

5.10. How much influence do you have over the variety of tasks you perform?

Very little
A moderate amount
Much
Very much

5.11. How much influence do you have over the order in which you perform tasks at work?

Very little
5.12. How much influence do you have over the amount of work you do?

Very little
A moderate amount
Much
Very much

5.13. How much influence do you have over the quality of the work that you do?

Very little
A moderate amount
Much
Very much

5.14. How much influence do you have over the arrangement of and decoration of your work area?

Very little
A moderate amount
Much
Very much

5.15. How much influence do you have over the decisions concerning which individuals in your work unit do which tasks?

Very little
A moderate amount
Much
Very much
5.16. How much influence do you have over the decisions as to when things will be done in your work unit?

Very little
A moderate amount
Much
Very much

5.17. How much influence do you have over the policies, procedures, and performance in your work unit?

Very little
A moderate amount
Much
Very much

5.18. How much influence do you have over the training of other workers in your work unit?

Very little
A moderate amount
Much
Very much

5.19. How much influence do you have over the arrangement of furniture and other work equipment in your work unit?

Very little
A moderate amount
Much
Very much
5.20. In general, how much influence do you have over work and work-related factors?

Very little
A moderate amount
Much
Very much

5.21. **The following questions will ask about supervisor support.**

5.22. How much does your immediate supervisor go out of his/her way to do things to make your life easier?

Very little
A moderate amount
Much
Very Much

5.23. How easy is it to talk with people who work in the department, other than your supervisor?

Not at all
A little easy
Easy
Very easy

5.24. How much can people who work in the department, other than your supervisor, be relied on when things get tough (stressful) at work?

Very little
A moderate amount
Much
Very much
5.25. How much are people who work in the department, other than your supervisor, willing to listen to you personal problems?

Very little
A moderate amount
Much
Very much

5.26. How often are people who work in the hospital, other than your supervisor, available to assist you when needed with a specific task that is part of your job?

Rarely
Occasionally
Sometimes
Fairly often
Very often

5.27. The following question will ask about interactions with patients.

5.28. How often do you interact with difficult patients?

Rarely
Occasionally
Sometimes
Fairly often
Very often

5.29. The following questions will ask about work load.

5.30. How often does your job require you to work very fast?

Rarely
5.31. How often does your job require you to work very hard?

Rarely
Occasionally
Sometimes
Fairly often
Very often

5.32. How often does your job leave you with little time to get things done?

Rarely
Occasionally
Sometimes
Fairly often
Very often

5.33. How often is there a great deal to be done?

Rarely
Occasionally
Sometimes
Fairly often
Very often

5.34. The following questions will ask about time pressure at work.

5.35. How often do you feel pressure to keep working instead of taking a break?
5.36. How often do you feel a sense of urgency at work?

Never
Occasionally
Often
Always

5.37. The following questions will ask about job satisfaction.

5.38. All in all, how satisfied are you with your job?

Not at all satisfied
Not very satisfied
Somewhat satisfied
Very satisfied

5.39. If you were free to go into any type of job you wanted, what would you choose?

Job I have now
To retire and not work at all
Some job other than the one I have now

5.40. Knowing what you know now, if you had to decide all over again whether to take the job you now have, what would you decide?

Decide without hesitation to take the same job
Would have second thoughts
Would decide definitely not to take the same job
5.41. In general, how well would you say that your job measures up to the sort of job you wanted when you took it?

Very much like the job I wanted
Somewhat like the job I wanted
Not much like the job I wanted

5.42. If a good friend of yours told you he or she was interested in working in a job like yours for your employer, what would you tell him or her?

I would strongly recommend it
I would have doubts about recommending it
I would advise the friend against it

5.43. The following questions will ask about activities outside of work.

5.44. How often do you participate in exercise involving your lower extremities during leisure time (e.g., running, walking, resistance training, dancing, pilates, yoga, etc.)?

Rarely/Never
1-2 days per week
3-5 times per week
Daily

5.45. Outside of work, do you lift, carry, or provide physical care for children on a regular basis?

Yes
No
5.46. Outside of work, do you lift, carry, or provide physical care for any teenagers or adults on a regular basis?

Yes
No

5.47. How often do you do housework (e.g., cleaning, cooking, and doing laundry)?

Less than once a week
Once a week
2-3 days per week
4-5 days per week
Daily

5.48. How would you describe your overall health status?

Excellent
Very Good
Good
Fair
Poor

5.49. On average, how many hours of sleep do you get each day?

< 5 hrs
5 to < 6 hrs
6 to < 7 hrs
7 to < 8 hrs
8 hrs or more

5.50. How would you describe the quality of your sleep?

Excellent
5.51. This concludes the survey. Thank you for your participation!