

Posture Survey

This survey should be filled out by a parent/guardian. The following questions are being asked of all children to assess their predisposition to posture related musculoskeletal disorders, e.g., backpack injuries, computer related injuries, etc. Your responses would be held in the strictest confidence. Please fill out a different form for each child.

Name of child:
Completed age (in years):
Class:
School:

Weight (in kg):
Height (in cm):
Gender:
City:

- | | | |
|---------------------------------------------------------------------------------------------------------------------------------------------|-----|----|
| 1. Does your child's head usually tilt on one side? | Yes | No |
| 2. Is one shoulder usually higher than the other? | Yes | No |
| 3. Did you notice an unleveling of the pelvis (one hip higher than the other)? | Yes | No |
| 4. Does your child wear the backpack over just one shoulder? | Yes | No |
| 5. Does your child lean forward at the waist as a result of the weight of the back pack? | Yes | No |
| 6. Is your child's head and neck bent forward or upward when using the backpack? Yes | No | |
| 7. Has your child ever missed school due to pain in the back, neck or limbs? | Yes | No |
| 8. Does your child use a computer at school?
Duration _____hours/week | Yes | No |
| 9. Does your child use a computer at home?
Duration _____hours/week | Yes | No |
| 10. How long does your child wear a backpack every day? _____hours/day | | |
| 11. How often does your child participate in sports or exercise outside of school? _____hours/week | | |
| 12. Does your child have any other medical illnesses, e.g., asthma, heart disorders, etc. (mention the disorder)? _____ | | |
| 13. Please weigh the backpack of your child on an average school day _____kg | | |
| 14. What treatment (if any) has your child received for pain? _____ | | |
| 15. Please indicate if the school has undertaken any remedial measures to prevent backpack injuries (e.g., lockers, worksheets, etc.) _____ | | |
| 16. Any other comments/suggestions to solve these problems _____ | | |

How often does your child complain of (tick one box):

	Never	Almost never	Sometimes	Often	Always
Headache					
Neck Pain					
Shoulder Pain					
Mid Back Pain					
Low Back Pain					
Burning sensation					
Numbness or Tingling					
Leg Pain					
Weakness of Hand					
Swelling or redness of shoulders or neck					

Your contact details:

Your Name: _____
Postal Address: _____
City: _____ State: _____ PIN: _____
Telephone: _____ E-mail: _____

Thank you for filling out the form. You will receive further information on Backpack Safety shortly.

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