Self-reported musculoskeletal problems amongst professional truck drivers

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WORK
1a. Are you currently employed?

[ ] Yes  [ ] No  [ ] If No, please go to Q4.

b. If Yes, what was your main occupation during the past week?

______________________________________________________________

c. In what industry did you carry out this occupation? (eg. farming, quarrying, road haulage)

______________________________________________________________

d. On what date did you start in this industry?
Month (if known): _____ Year: ______

e. Does an average day involve lifting or moving weights of:

i). 20 lbs (10 kg)  [ ] Yes  [ ] No
or more by hand

ii). 56 lbs (25 kg)  [ ] Yes  [ ] No
or more by hand

iii). Work on a night shift  [ ] Yes  [ ] No

VIBRATION EXPOSURE
2a. During the past week, did you drive, ride or stand on any kind of vehicle or machine at work?

[ ] Yes  [ ] No  [ ] If No, please go to Q4.

If Yes, please give the following information:

b. Vehicle type(s) (eg. car, agricultural tractor, HGV, bus, off-road vehicle etc):

______________________________________________________________

c. Make(s) and model(s) of vehicle(s) (eg. Scania 143, Mercedes Atego, if known):

______________________________________________________________

d. Year(s) of manufacture (if known):

______________________________________________________________

e. For the vehicle you used most, please circle or mark the seat comfort on the following 1-7 scale:

<table>
<thead>
<tr>
<th>Very Comfortable</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>Very Uncomfortable</th>
</tr>
</thead>
</table>

f. Does the vehicle you used most have a suspension seat?

[ ] Yes  [ ] No

g. If Yes, do you find this easy to adjust?

[ ] Yes  [ ] No

h. Does the drivers seat of the vehicle used most have:

i) armrests?

[ ] Yes  [ ] No

ii) an adjustable lumbar support

[ ] Yes  [ ] No

3a. For those machines or vehicles that you have just mentioned, we would like to know the total number of hours (or minutes) that you drove / rode / stood on them over the whole week. (please count only the time that the ENGINE WAS RUNNING or POWER ON. If you cannot give the exact time, please give your best estimate).

Name of machine / vehicle:  
Time used in a typical week:

1. ________________________  
   hours mins

2. ________________________  
   hours mins

3. ________________________  
   hours mins

4. ________________________  
   hours mins

b. Was the time you spent over the past week riding / driving / standing on such machines typical of the job?

[ ] Yes  [ ] No

If Not applicable, please go to Q4.

c. If No, in what way was it unusual?

______________________________________________________________
d. In your main job, do you ever ride on / drive / stand on any other vehicles or machines that cause vibration or frequent jolting that you can feel (eg. vehicles only used occasionally or at certain times of the year)?

☐ Yes  ☐ No

If Yes, which vehicles / machines? ______ ____________________________________

e. In your spare time (ie. outside work and going to and from work, please estimate the total number of hours (or minutes) you spent driving or riding in the vehicles listed below. If you cannot give the exact time, please give your best estimate.

Car or Van  ___________ hours ___________ mins  
Train  ___________ hours ___________ mins  
Bus or Coach  ___________ hours ___________ mins  
Motorcycle  ___________ hours ___________ mins  

HEALTH

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

<table>
<thead>
<tr>
<th>Musculoskeletal problems</th>
<th>Have you at any time during the last 12 months had trouble (ache, pain, discomfort) in:</th>
<th>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?</th>
<th>Have you had trouble at any time during the last 7 days?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Wrist/hand</td>
<td>☐ No</td>
<td>☐ No</td>
<td>☐ No</td>
</tr>
<tr>
<td></td>
<td>☐ Yes</td>
<td>☐ Yes</td>
<td>☐ Yes</td>
</tr>
<tr>
<td>Upper back</td>
<td>☐ No</td>
<td>☐ No</td>
<td>☐ No</td>
</tr>
<tr>
<td></td>
<td>☐ Yes</td>
<td>☐ Yes</td>
<td>☐ Yes</td>
</tr>
<tr>
<td>Lower back</td>
<td>☐ No</td>
<td>☐ No</td>
<td>☐ No</td>
</tr>
<tr>
<td></td>
<td>☐ Yes</td>
<td>☐ Yes</td>
<td>☐ Yes</td>
</tr>
<tr>
<td>One or both ankles/feet</td>
<td>☐ No</td>
<td>☐ No</td>
<td>☐ No</td>
</tr>
<tr>
<td></td>
<td>☐ Yes</td>
<td>☐ Yes</td>
<td>☐ Yes</td>
</tr>
</tbody>
</table>
b. Have you ever had any low back trouble (ache, pain, numbness or discomfort)?

| Yes | No |

If No, please go to Q5a.

c. Have you ever hurt your low back in an accident?

| Yes | No |

d. If Yes, was the accident at work?

| Yes | No |

What was the approximate date of the accident?

| month | year |

e. Have you ever had to change jobs or duties because of low back trouble?

| Yes | No |

f. What do you think brought on this problem with your back?

Accident  Activity at Work  Sporting Activity  Other (please specify) __________

________________________________________________________

________________________________________________________

g. What is the total length of time you have had low back trouble during the last 12 months?

| 0 days | 1-7 days | 8-30 days | More than 30 days |

If 0, please go to Q5a.

h. Has low back trouble caused you to reduce your activity during the last 12 months?

i. work activity

| Yes | No |

ii. leisure activity

| Yes | No |

i. What is the total length of time that low back trouble has prevented you from doing your normal work (at home or away from home) during the last 12 months?

| 0 days | 1-7 days | 8-30 days | More than 30 days |

j. Have you been seen by a doctor, physiotherapist, chiropractor or other such person because of low back trouble during the last 12 months?

| Yes | No |

k. Please give details of any issues regarding vibration and back pain that have not been discussed by this questionnaire: __________

________________________________________________________

________________________________________________________

DETAILS

5a. Please fill in your date of birth:

| day | month | year |

b. Sex:

| male | female |

c. What is your weight?

| stones | pounds | kg |

d. What is your height?

| feet | inches | cm |

e. Are you right or left handed?

| right | left | able to use both hands equally |

f. Are you a:

| smoker | non-smoker | ex-smoker |

Thank you very much for your time!

Please write your address or e-mail address if you would like to be sent a summary of our results:

________________________________________________________