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) or more by hand

   Yes  No

   ii). 56 lbs (25 kg) or more by hand

   Yes  No

   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:

   Very Comfortable 1 2 3 4 5 6 7 Very Uncomfortable

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?

   Not applicable  Yes  No

   (don’t ride or drive vehicle or machine)

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).

4a. Musculoskeletal problems

<table>
<thead>
<tr>
<th></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 / hands</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></td>
<td>☐ Yes, in right wrist / hand</td>
<td>☐ No</td>
<td>☐ No</td>
</tr>
<tr>
<td></td>
<td>☐ Yes, in left wrist / hand</td>
<td>☐ Yes</td>
<td>☐ Yes</td>
</tr>
<tr>
<td></td>
<td>☐ Yes, in both wrists / hands</td>
<td>☐ Yes</td>
<td>☐ No</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>(small of back)</td>
<td>☐ Yes</td>
<td>☐ Yes</td>
<td>☐ Yes</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

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

Yes  No

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

Accident  Activity at Work  Sporting Activity  Other (please specify)  

f. How bad was the pain during the worst episode?

Mild  Severe  Very, Very Severe

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

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

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

i. work activity

Yes  No  [If 0, please go to Q5a.]

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:

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:

____________________________________  
____________________________________