Visual Analogue Scale Form

Date:___/___/_____ Patient Name:_____

Please make an “X” or a “/” along the line below to indicate your level of pain.
You may make two marks to indicate “at it’s worst” and “presently.”

Head, Neck, Arm (circle one)

No Pain  Worst Pain

Mid-back, Ribs, Breastbone (circle one)

No Pain  Worst Pain

Low Back, Leg/Buttock, Genitals

No Pain  Worst Pain

Other _____

No Pain  Worst Pain

Patient Signature _____ Date ___/___/_____