Name ____ Date______________

VISUAL ANALOG SCALE FOR PAIN/DISCOMFORT

INSTRUCTIONS: List your major complaints and rate your pain and discomfort.

		NONE										EXTREME
1.	____	0	1	2	3	4	5	6	7	8	9	10
2.	____	0	1	2	3	4	5	6	7	8	9	10
3.	____	0	1	2	3	4	5	6	7	8	9	10
4.	____	0	1	2	3	4	5	6	7	8	9	10
5.	____	0	1	2	3	4	5	6	7	8	9	10

Comments: ____
____
____

Patient Signature:_____________________________