

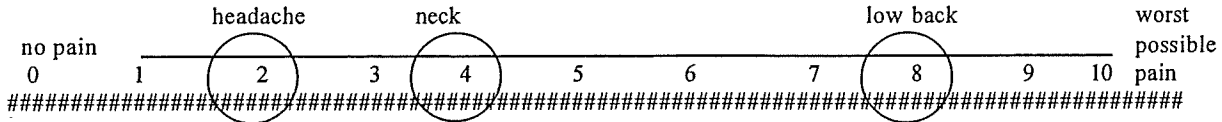
NAME _____ AGE _____ DATE _____

QUADRUPLE VISUAL ANALOGUE SCALE

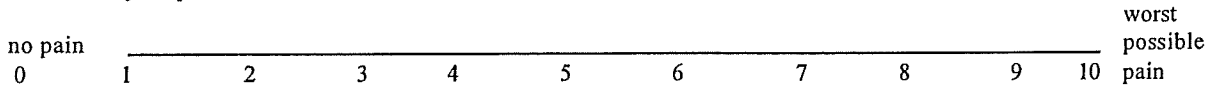
INSTRUCTIONS: Please *circle* the number that best describes the question being asked.

NOTE: If you have more than one complaint, please answer each question for each individual complaint and indicate the score for each complaint. Please indicate your average pain levels and pain at minimum / maximum using the last _____ (Doctor: fill in the desired time interval) as your reference. If you have completed this form before, indicate your average pain level *after* the last time you completed this form (Applies to Question #2.).

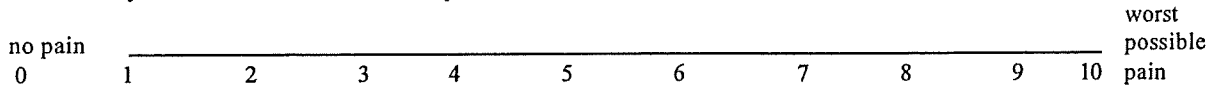
EXAMPLE:



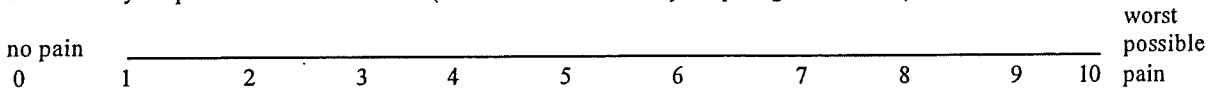
1. What is your pain RIGHT NOW?



2. What is your TYPICAL or AVERAGE pain?

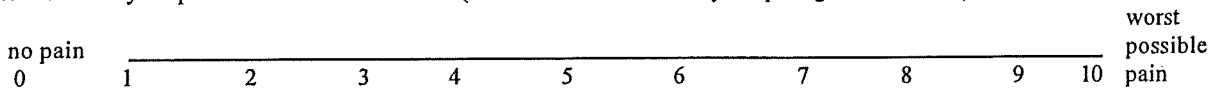


3. What is your pain level AT ITS BEST (How close to "0" does your pain get at its best)?



What percentage of your awake hours is your pain at its best? _____%

4. What is your pain level AT ITS WORST (How close to "10" does your pain get at its worst)?



What percentage of your awake hours is your pain at its worst? _____%

For Doctor Use Only:

SCORE: #1 _____ + #2 _____ + #4 _____ = _____ / 3 x 10 = _____ (Low intensity = <50; High intensity = >50)

TOTAL SCORE _____