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QUADRUPLE VISUAL ANALOGUE SCALE

Name: _____ Age: _____ Date: _____

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:

Headache Neck Low Back

No pain _____ **worst possible pain**

0 1 (2) 3 (4) 5 6 7 (8) 9 10

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1 - What is your pain RIGHT NOW?

No pain _____ **worst possible pain**

(0) (1) (2) (3) (4) (5) (6) (7) (8) (9) (10)

2 - What is your TYPICAL or AVERAGE pain?

No pain _____ **worst possible pain**

(0) (1) (2) (3) (4) (5) (6) (7) (8) (9) (10)

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

No pain _____ **worst possible pain**

(0) (1) (2) (3) (4) (5) (6) (7) (8) (9) (10)

What percentage of your awake hours in 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)?

No pain _____ **worst possible pain**

(0) (1) (2) (3) (4) (5) (6) (7) (8) (9) (10)

For Doctor Use Only:

SCORE: #1 _____ + #2 _____ +#4 _____ = _____ / 3x10 = _____ (Low intensity =<50; High intensity =>50)

TOTAL SCORE _____

Reset Submit