VAS – Visual Analog Scale

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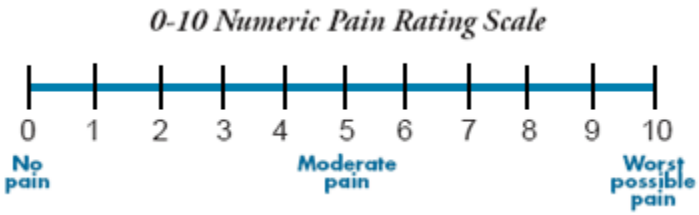
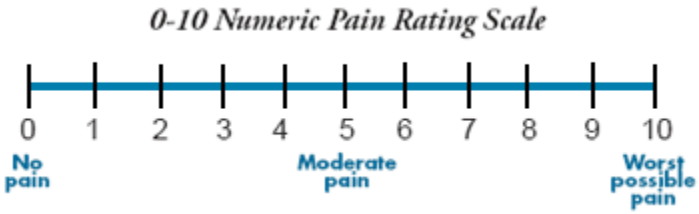
Patient:_____Date:_____

1. **WHERE IS YOUR PAIN LOCATED?** head neck mid back low back_____

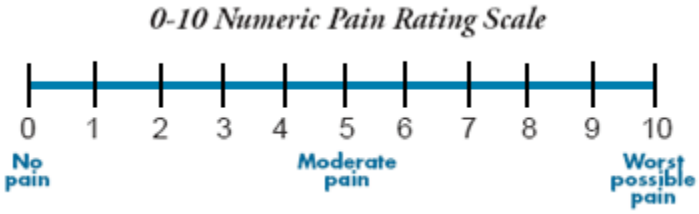
2. **WHAT IS PAIN LEVEL <u>RIGHT NOW</u>?** Please circle



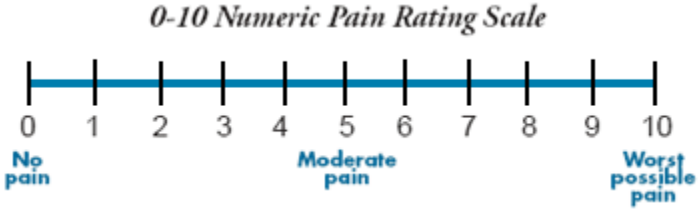
3. **WHAT IS YOUR PAIN AT <u>ITS WORST</u>?** Please circle



4. **WHAT IS YOUR PAIN LEVEL <u>AT ITS BEST</u>?** Please circle



5. **WHAT WAS YOUR INITIAL PAIN LEVEL <u>BEFORE</u> BEING TREATED AT THIS OFFICE?** Please circle



PATIENT SIGNATURE:_____DATE:_____