QUADRUPLE VISUAL ANALOGUE SCALE

Patient Name _____   Date _____

List Current Pains, Complaints
and/or Conditions in the order
of their of severity:

◯ 1) _____   ▢ 3) _____

△ 2) _____   ✗ 4) _____

Please read carefully:

Rate each of your pain(s)/complaint(s) in four different ways: <u>at its best</u>, <u>at its worst</u>, <u>right now</u> and <u>on average</u>.

If you have more than one complaint, please answer each question for each separate complaint by marking the score for it on the lines below. Use the symbol at the beginning of each complaint above to designate the number from 0 to 10 that best describes the question being asked. It is possible that more than one complaint has the same rating.

Example:

	Arm 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 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**

2 – 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**

3 – What is your pain level RIGHT NOW?

No pain _____ worst possible pain

    0   **1**   **2**   **3**   **4**   **5**   **6**   **7**   **8**   **9**   **10**

4 – What is your TYPICAL pain level ON AVERAGE throughout the day?

No pain _____ worst possible pain

    0   **1**   **2**   **3**   **4**   **5**   **6**   **7**   **8**   **9**   **10**

OTHER COMMENTS:

_____

_____   Score _____

                                                     Examiner _____