

Visual Analog Pain Scale

Name _____ Date _____ Account # _____

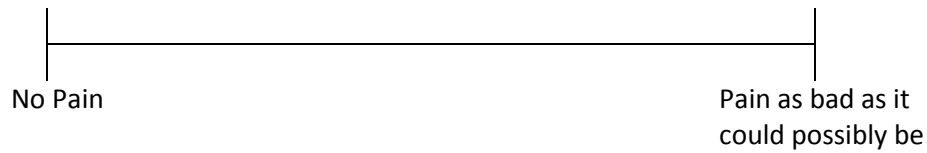
First Area of Concern: Location _____

Please place a mark on the line to indicate how much pain you experience



Second Area of Concern: Location _____

Please place a mark on the line to indicate how much pain you experience



Third Area of Concern: Location _____

Please place a mark on the line to indicate how much pain you experience

