1303 W. Evergreen Ave.
Effingham, IL 62401
(217) 342-3400

VISUAL ANALOG SCALE

Patient Name: ____________________________________ DOB: ______________ Date: ___________

1. Interval:

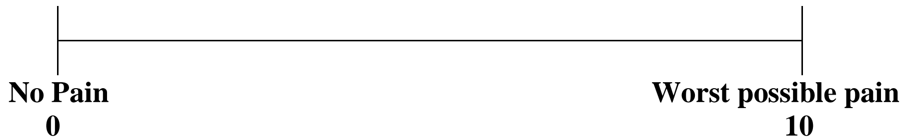
□ Baseline	□ 42-day	□ 90-day	□ 180-day
□ 365-day	□ 730-day	□ 3 years	□ 4 years
□ 5 years	□ 6 years	□ 7 years	□ Other, specify _______

A. LEG PAIN VISUAL ANALOG SCALE (to be completed by patient)

Directions:

Indicate the severity of your LEG pain by marking a single | on the line that describes your current level of leg pain TODAY, ranging from "no pain" to "worst possible pain."

RIGHT LEG



No Pain **Worst possible pain**
0 **10**

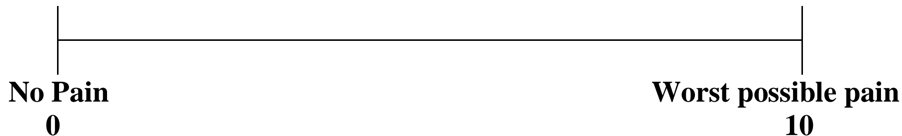
LEFT LEG

No Pain **Worst possible pain**
0 **10**

B. BACK PAIN VISUAL ANALOG SCALE (to be completed by patient)

Directions:

Indicate the severity of your BACK pain by marking a single | on the line that describes your current level of leg pain TODAY, ranging from "no pain" to "worst possible pain."



No Pain **Worst possible pain**
0 **10**

______________ ______/______/_____
Patient Initials Date

C. CONFIRMATION OF INVESTIGATOR REVIEW

____ ______/_____/_____
Signature of Investigator Date