# Visual Analogue Scale of Spinal Pain

Name__________________________________________________________________Date __________/________/_______________

Please mark on the 1 to 10 scale your involvement with p;ain to the following ocations and situation, from no involvement (0) to maximum involvement (10). Mark the scale with a circle around the number on the line.:

1. Do you have any pain in your neck? How severe is it?

   0_____ 1_____ 2 _____ 3 ______ 4 _____ 5 _____ 6 _____ 7 _____ 8 _____ 9 _____ 10

   No pain Intolerable

2. Do you have any pain between your shoulder blades? How severe is it?

   0_____ 1_____ 2 _____ 3 ______ 4 _____ 5 _____ 6 _____ 7 _____ 8 _____ 9 _____ 10

   No Pain Intolerable

3. Do you have any pain in your low back? How severe is it?

   0_____ 1_____ 2 _____ 3 ______ 4 _____ 5 _____ 6 _____ 7 _____ 8 _____ 9 _____ 10

   No Pain Intolerable

4. Do you any pain at night? How severe is it?

   0_____ 1_____ 2 _____ 3 ______ 4 _____ 5 _____ 6 _____ 7 _____ 8 _____ 9 _____ 10

   No Pain Intolerable

5. Does activity give you pain? Yes ____ No ____ If so, how much activity is required to cause you pain?

   0_____ 1_____ 2 _____ 3 ______ 4 _____ 5 _____ 6 _____ 7 _____ 8 _____ 9 _____ 10

   A great deal of activity Almost no activity

6. Do use pain killers? Yes ____ No ____ If so, how much relief?

   0_____ 1_____ 2 _____ 3 ______ 4 _____ 5 _____ 6 _____ 7 _____ 8 _____ 9 _____ 10

   Complete relief No Relief

7. Do you have any stiffness in your neck or low back?

   0_____ 1_____ 2 _____ 3 ______ 4 _____ 5 _____ 6 _____ 7 _____ 8 _____ 9 _____ 10

   No Stiffness Intolerable Stiffness

8. Do you have any pain in your shoulder and or arm? How severe is it? (Mark for Right and Left)

   Right: 0_____ 1_____ 2 _____ 3 ______ 4 _____ 5 _____ 6 _____ 7 _____ 8 _____ 9 _____ 10

   Left: 0_____ 1_____ 2 _____ 3 ______ 4 _____ 5 _____ 6 _____ 7 _____ 8 _____ 9 _____ 10

   None at all Intolerable

9. Does your pain interfere with the use of your arm and/or hand ? Mark for Right and Left)

   Right: 0_____ 1_____ 2 _____ 3 ______ 4 _____ 5 _____ 6 _____ 7 _____ 8 _____ 9 _____ 10

   Left: 0_____ 1_____ 2 _____ 3 ______ 4 _____ 5 _____ 6 _____ 7 _____ 8 _____ 9 _____ 10

   None at all Not able to use it at all

10. Do you have any pain in your neck? How severe is it?

    Right: 0_____ 1_____ 2 _____ 3 ______ 4 _____ 5 _____ 6 _____ 7 _____ 8 _____ 9 _____ 10

    Left: 0_____ 1_____ 2 _____ 3 ______ 4 _____ 5 _____ 6 _____ 7 _____ 8 _____ 9 _____ 10

    None at all Intolerable

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Name_______________________________________________________________________Date __________/________/_______________

11. Do you have headaches? How severe is it?

0_____ 1_____ 2 _____ 3 ______ 4 _____ 5 _____ 6 _____ 7 _____ 8 _____ 9 _____ 10
None at all — Intolerable

12. How frequent are your headaches, if you have them?

0_____ 1_____ 2 _____ 3 ______ 4 _____ 5 _____ 6 _____ 7 _____ 8 _____ 9 _____ 10
Infrequent — All the time

13. Does your back pain interfere with your ability to walk?

0_____ 1_____ 2 _____ 3 ______ 4 _____ 5 _____ 6 _____ 7 _____ 8 _____ 9 _____ 10
Complete freedom to walk — Completely unable to walk because of pain

14. Does your pain interfere with your ability to stand still?

0_____ 1_____ 2 _____ 3 ______ 4 _____ 5 _____ 6 _____ 7 _____ 8 _____ 9 _____ 10
Can stand still for an hour or more — Not able to stand still at all

15. Does your pain interfere with you sitting in a chair?

0_____ 1_____ 2 _____ 3 ______ 4 _____ 5 _____ 6 _____ 7 _____ 8 _____ 9 _____ 10
Complete comfort — Such discomfort that I cannot sit in a chair at all

16. Is your pain worse riding in a car?

0_____ 1_____ 2 _____ 3 ______ 4 _____ 5 _____ 6 _____ 7 _____ 8 _____ 9 _____ 10

Complete freedom to ride in a car — Such discomfort that I cannot ride in a care at all

17. Do you have pain laying down in bed?

0_____ 1_____ 2 _____ 3 ______ 4 _____ 5 _____ 6 _____ 7 _____ 8 _____ 9 _____ 10
Complete comfort — No \ comfort at all.

18. What is your overall handicap in your complete life-style because of pain.

0_____ 1_____ 2 _____ 3 ______ 4 _____ 5 _____ 6 _____ 7 _____ 8 _____ 9 _____ 10
Completely free to perform any task — Totally7 handicapped

19. To what extent does your pain interfere with you ability to work?

0_____ 1_____ 2 _____ 3 ______ 4 _____ 5 _____ 6 _____ 7 _____ 8 _____ 9 _____ 10
No Intereference at all — Totally incapable of work

20. To what extent does your work have to be modified so that you are able to do your job?

0_____ 1_____ 2 _____ 3 ______ 4 _____ 5 _____ 6 _____ 7 _____ 8 _____ 9 _____ 10
No adjustment to work — So much adjustment that I have had to chnge jobs.