Name:_____ **Date:**_____

VAS Pain Scale

In the past 48 hours, how would you rate your pain?

	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
No Pain	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**Worst Pain Imaginable**