# FORM: VAS PAIN
# VAS PAIN SCORE

DATE OF ASSESSMENT ☐☐ ☐☐ ☐☐ DATE OF SURGERY ☐☐ ☐☐ ☐☐

PATIENT INITIALS ____________

HOSPITAL PATIENT NUMBER ____________

**TO BE COMPLETED BY THE PATIENT**
Please answer the below question

There's no 'right or wrong' answer. Just tell us how you feel.
Thank you.

Please place a mark along the line below to indicate the amount of **PAIN** that you have experienced

**No Pain**

**Worst Possible Pain**

PATIENTS INITIALS ☐☐☐ DATE ☐☐ ☐☐ ☐☐