Lower Back Pain Assessment Form

Patient Information:
Full Name:
Date of Birth:
Gender:
Contact Information:
Medical History:
1. Previous history of lower back pain:
2. Any recent injuries or accidents:
Pain Description:
1. Onset of pain:
2. Location of pain:
3. Intensity of pain (scale of 0 to 10):
4. Type of pain:

Pain Triggers:
Activities that worsen the pain:
Pain Relief Measures:
Medications used for pain relief:
Home remedies or self-care:
Daily Activities:
Impact of pain on daily activities:
Medical Examination:
Physical examination findings:
Diagnostic Tests (if applicable):

Treatment Plan:
Recommended treatment:
Follow-up appointments
Patient's Signature:
Date: