

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: