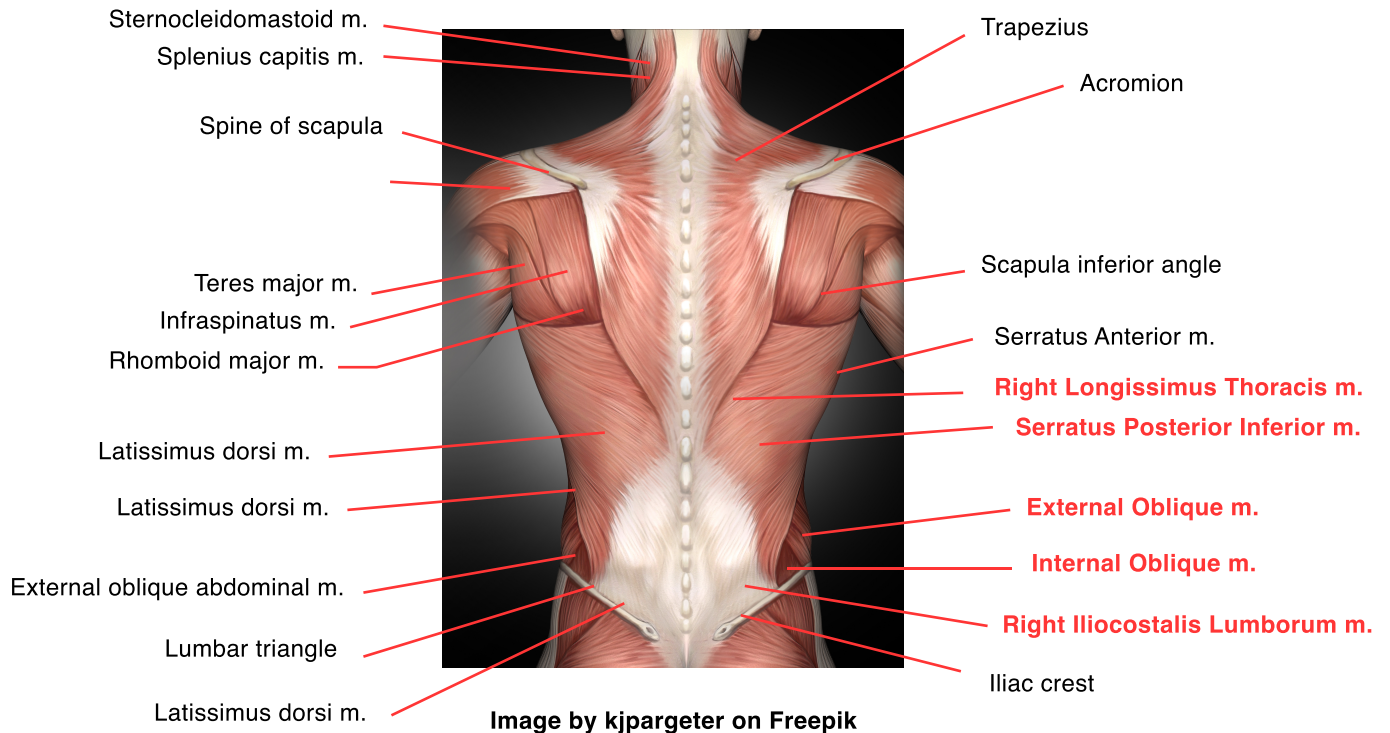


Lower Back Pain Location Chart

Patient Information

Name: _____

Medical Record Number: _____ Date of Assessment: _____



Pain Location:

Pain Characteristics

- Type of Pain (e.g., sharp, dull, burning): _____
- Pain Intensity (on a scale of 0-10): _____
- Duration of Pain: _____
- Any Radiation of Pain (if applicable): _____
- Triggers or Aggravating Factors: _____

Additional Notes

Provider's Assessment:

- Provider's Name: _____
- Date of Assessment: _____
- Diagnosis or Assessment: _____
- Treatment Plan: _____
- Next Steps or Follow-up Recommendations: _____

Patient Signature: _____ Date: _____

Provider Signature: _____ Date: _____