

Lower Back Pain Assessment Form

Patient Information

Full Name

Date of Birth

Gender

Pain Assessment

Onset of Pain

Pain Location

Duration of Pain

Pain Intensity (0-10)

Character of Pain (e.g., sharp, dull, throbbing)

Aggravating Factors

Relieving Factors

Associated Symptoms

Describe any associated symptoms (e.g., numbness, tingling, weakness)

Medical History

Relevant Medical/Surgical History

Social History

Occupation

Physical Activity Level

Additional Comments