

# LOW BACK PAIN ACTION PLAN

Name: \_\_\_\_\_

Medical Provider's  
 Name: \_\_\_\_\_

Case Manager's  
 Name: \_\_\_\_\_

Medical Social Worker's  
 Name: \_\_\_\_\_

Phone: \_\_\_\_\_

Phone: \_\_\_\_\_

Phone: \_\_\_\_\_

## THINGS TO DO EVERYDAY:

Use good lifting techniques:

- Bend at my knees
- Hold objects close to my body
- Push (don't pull) objects
- Get help if the object is heavy or awkward

Get a good night's sleep:

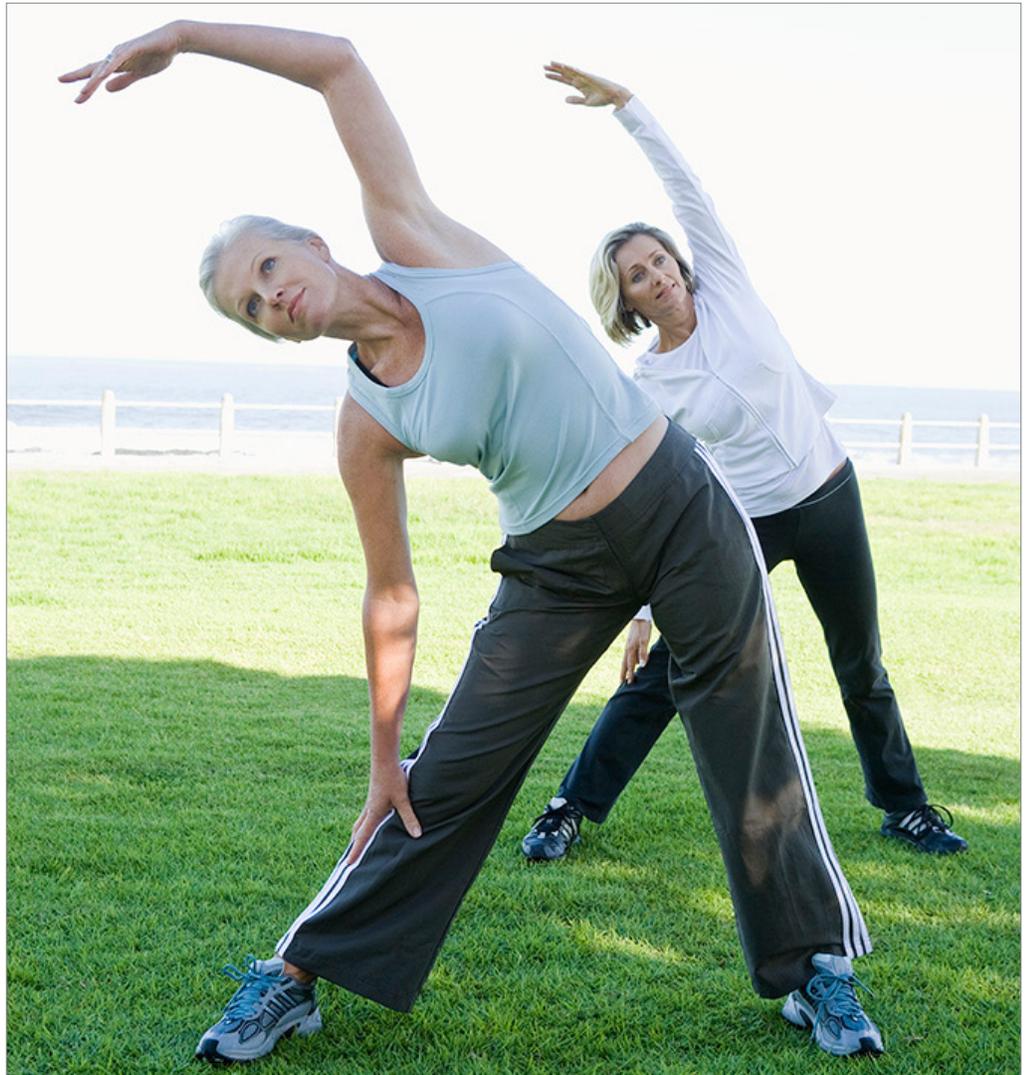
- Take a warm bath before bed
- Sleep on my side with a pillow between my knees
- Sleep on my back with a pillow under my knees

## MANAGE MY PAIN:

- Stay active, but let my pain level guide me
- Try relaxation techniques
- Spend time with supportive friends and family sharing my thoughts
- Keep a healthy weight
- Have a good posture
- Take breaks to stretch at work or on long car rides
- Do exercises directed by my provider to reduce pain

## GOALS:

Date:	My Weight:	My Goal:



## MY PLAN:

**If I have a flare up of low back pain, I will:**

- Use a heating pad or take a warm bath
- Stretch
- Take medicines for back pain as directed by my medical provider
- Call my medical provider if I am not feeling any better

**I will call my medical provider immediately if:**

- If I have pain, weakness or tingling in my legs or I cannot control my urine or stool

## NOTES:

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## MY ACTION PLAN

**Goal:** Something I WANT to do (Example: increase physical activity, take medication, make healthier food choices, etc.)

**Action:** A specific activity that you are going to do in the next 1 to 2 weeks. (Example: I will walk for 30 minutes after dinner with my dog three days each week for the next two weeks.)

What you will do (the behavior):

How much you will do (time, distance, or amount of activity):

When you will do it (time of day):

How often you will do it (number of days per week):

How important is it to you that you complete the action plan you made above? (Fill in your response.)

Not at all important      1   2   3   4   5   6   7   8   9   10      Totally important  
                          

How confident are you that you will successfully complete the action plan you made above? (Fill in your response.)

Not at all confident      1   2   3   4   5   6   7   8   9   10      Totally confident  
                          

Things that might make it hard:

Ways I might overcome these problems:

Follow-up plan (phone or e-mail and date/time):