Todays Date:_____

HIP QUESTIONAIRE

NAME:_____ **REFERRED BY?**_____

Which HIP are we seeing you for today (please circle)? Right Left Both
Occupation:_____ Are you currently working: _____
Do you feel your injury is work related? Yes No
Is there an open work comp claim for this injury? Yes No
Is your claim in Litigation? Yes No

How was your hip injured (Include date, if any, and how long you have had a problem)?

_____

_____

PAIN

Where exactly is most of your pain (please circle): Back Buttock, Side of hip, Thigh, Groin
Frequency of pain: Constant Intermittent
Pain Scale (circle one): 1 2 3 4 5 6 7 8 9 10
Mild Moderate Severe
Aggravating activities (please circle):
Stairs Uneven ground Prolonged sitting running climbing
squatting kneeling Lying on affected side at night
Other:_____
Prolonged standing/walking: Time: _____ Distance: _____

Walking aid used: None Cane Walker Crutches Wheelchair Motorized Scooter

Locking, Catching, Clicking, giving away Yes No

Hip or leg swelling Yes No

Does pain radiate down the leg? Yes No

Leg numbness? Yes No

Hisotry of back pain, back problems or back surgery? Yes No

Prior hip surgery or problems ? Yes No

Treatment Received for current condition
Medications _____
Injections _____
Physical Therapy (How many sessions) _____
Surgery _____
Other Physicians _____
Chiropractic _____