HIP QUESTIONNAIRE

Patient Name: ____ DOB: __________________________

1.) Which hip(s) did you hurt? ____
2.) Is this a new presentation of hip pain, or a follow-up?____
3.) Did another provider refer you? If yes, who?____
4.) Describe **how** and **where** your symptoms occurred/how you injured your hip? Be specific (include **dates**)
____
____

5.) What best describes your hip pain? (check all that apply)

__aching __diminishing __grinding __progressive __swelling
__burning __dull __improving __radiating __tender to touch
__catching __electric __pins and needles __sharp __throbbing
__clicking __giving way __popping __stabbing __worsening
__cramp-like __gradual __pressure __staying the same other:______________

6.) What is associated with your hip pain? (check all that apply)

__leg falling asleep
__back pain
__chills
__difficulty arising from a seated position
__difficulty getting into and out of car
__falling down
__fevers
__foot numbness
__gait instability
__groin pain
__joint swelling
__leg weakness
__limited ROM of hip
__limited ROM of knee
__loss of balance
__requiring a cane
__requiring a walker
__requiring a wheelchair
__requiring an assistant for ambulation
__requiring an assistant for transfers
__requiring crutches
__sciatica
__stiffness
__thigh pain
__unsteady gait
__weakness
other:______________________

7.) Describe the timing of your pain? (check all that apply)

__began today __occurs episodically __occurs randomly other:_____________
__constantly occurs __occurs in the morning __occurs with activity
__occurs at night __occurs intermittently __occurs with weight bearing

8.) How severe is the pain on a scale of 0-10? (0 = no pain 10= worst pain)

currently ___/10 on a bad day ___/10 on an average day ___/10
initially ___/10 on a good day ___/10

9.) How long have you had your hip pain? ___years ___months ___weeks ___days

10.) What are you currently using to treat the hip pain? (check all that apply)

__brace __narcotics/pain meds __topical cream other:________________
__cast __anti-inflammatory meds __Tylenol
__muscle relaxants __physical therapy __no treatment

11.) Have you had any procedures or surgeries to treat the hip pain? If yes, what type?

____

12.) What diagnostic imaging studies have you had for this problem? (check all that apply)

__bone scan __MRI __no imaging studies
__CT scan __plain radiographs (X-ray) other:______________

13.) How has this problem limited you? (check all that apply)

__attending school on a limited basis __inability to perform ADL's __working on a limited basis
__difficulty with ADL's __inability to work __no limitations
__difficulty with REC sports participation __requiring constant asstance other:______________
__functional limitations __requiring occasional assistance
__inability to go to school __working light duty

14.) Who have you seen for this problem? (check all that apply)

__ER __another doctor __therapist __trainer __urgent care __walk-in clinic other:__________

I certify that I have read and understand the above information to the best of my knowledge, and that the above questions have been acurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the physician to release any information including the diagnosis and the records of any treatment or examination rendered to third party payors and/or health practicioners. I authorize and request my insurance company to pay directly to the physician insurance benefits otherwise payable to me. I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

Patient's Signature	MD/PA Signature	Date
____________	____________	________

Recall Review Signatures: Date:

1	____________	____________	________
2	____________	____________	________
3	____________	____________	________
4	____________	____________	________
5	____________	____________	________
6	____________	____________	________
7	____________	____________	________