

HIP QUESTIONNAIRE

DATE OF VISIT: _____ PATIENT NAME: _____

At baseline, what did/do you do for exercise and how often did/do you do each activity: _____

Which Hip is bothering you? ☐ RIGHT ☐ LEFT ☐ BOTH (which is worse: _____)

When did the pain begin? _____

Cause of pain: ☐ Gradual onset ☐ Sports injury ☐ Accident ☐ Work comp injury

If there an injury occurred, describe what happened and when? _____

Any prior significant issues with that Hip: ☐ No ☐ Yes

- Describe any previous injuries _____
- List any previous injections (when and with whom): _____
- List any previous surgeries (when, what, and surgeon's name): _____

Frequency of pain: ☐ Constant ☐ Intermittent

Pain level at rest, i.e. when not moving (please circle): 0 1 2 3 4 5 6 7 8 9 10 (10 is max)

Highest level of pain (please circle): 0 1 2 3 4 5 6 7 8 9 10 (10 is max)

Do you have buttock pain?: ☐ No ☐ Yes (describe when/what): _____

Do you have pain radiating down your leg?: ☐ No ☐ Yes: right / left / both (please circle)

Have you had back surgery or injections?: ☐ No ☐ Yes (describe when/what): _____

Have you have groin pain?: ☐ No ☐ Yes

Have you had a Hip replacement?: ☐ No ☐ Yes (please circle: Right Left)

Describe the pain: ☐ Aching ☐ Sharp ☐ Constant aching with sharp pain on movement

Do you experience : ☐ Grinding ☐ Catching (gets stuck for a moment) ☐ Locking (gets stuck and you have to manipulate it to unlock it) ☐ Buckling (gives out on you) ☐ Clicking ☐ Popping

☐ Snapping ☐ Feeling of instability ☐ Swelling

What causes pain: ☐ Sitting for long periods of time ☐ Going from sitting to standing ☐ Stairs

☐ Uphill/downhill walking ☐ Twisting ☐ Kneeling ☐ Squatting ☐ Getting in/out of car

When is pain the worst? ☐ Morning ☐ At the end of the day ☐ Trying to get to sleep

Is it hard to fall asleep? ☐ No ☐ Yes

Does pain wake you from sleep? ☐ No ☐ Yes

Have you tried any of the following to relieve pain? ☐ Rest ☐ Heat ☐ Cold ☐ Home exercises

☐ Massage ☐ Acupuncture

If you have had Physical Therapy: What facility: _____; How many sessions: _____

When was the last session: _____

List any medications taken for Hip pain (name, dosage, and frequency): _____

Are you getting: ☐ Better ☐ Worse ☐ No change