

HIP EVALUATION

NAME: _____ REFERRED BY: _____

DATE: _____ AGE: _____ HEIGHT: _____ WEIGHT: _____

When was your last visit with your PCP? _____

PLEASE CHECK THE APPROPRIATE BOX FOR YOUR RESPONSE

Which hip are you going to be seen for in our office? Left Right Both

If both, would you describe the pain as: left worse than right?

Or right worse than left?

Where is your pain located? Groin Thigh Knee Buttock Low back

How long have you had the pain? _____

Do you have pain with sitting? Yes No

How long can you comfortably sit? 15 minutes 30 minutes 1 hour No limit

How far are you able to walk? indoors only 1 block 5 blocks No limit

Do you have difficulty putting on your socks and shoes? Yes No

Do you have difficulty cutting your toenails? Yes No

Do you use a cane, crutches, or a walker? Always Sometimes Rarely Never

Does one leg feel shorter than the other? Yes No

If yes, which leg feels **shorter**? Left Right

What other limitations, if any, are you experiencing? _____

What are you taking for discomfort? _____

Were you diagnosed with hip problems as a child or adolescent? Yes No

Do you have or have you had any back problems or back surgeries? Yes No

Are you experiencing any numbness in your feet? Yes No

Do you have shooting pain down your legs? Yes No

Have you had any tests done on your hips? X-ray MRI CT Scan Bone Scan

Have you ever had any therapy for your hips? Yes No

If yes, which hip? Left Right Both

Have you had any fractures to your hips? Yes No

If yes, which hip? Left Right Both

Have you ever had a blood clot or DVT (deep vein thrombosis)? Yes No

Have you ever had any injections? Yes No

If yes, which hip? Left Right Both When was your last injection? _____

Have you had any surgery to your hips? Yes No

If yes, which hip? Left Right Both

Are you considering surgery? Yes No

If yes, how soon? Immediately 3 months 6 months more than 6 months