

Today's Date: _____

Physician Name: _____

Referring M.D.: _____

Name: _____ Age: _____

Occupation: _____

Which hip? Right _____ Left _____ Both _____

Describe injury (if any) and date of onset: _____

Have you experienced prior problems with this hip? Yes ___ No ___ When? _____

Describe: _____

Pain Scale (circle one):

1 2 3 4 5 6 7 8 9 10
Least moderate severe

Pain Quality:

Sharp Dull Throbbing
 Aching Burning

Do you walk with a limp? Yes ___ No ___

Do you use a cane/crutches? Yes ___ No ___

Can you put your shoes/socks on? Yes ___ No ___

Do you have pain at night? Yes ___ No ___

Do you have pain when sitting? Yes ___ No ___

Do you have pain when laying down or at night? Yes ___ No ___

Do you have groin pain? Yes ___ No ___

Do you have thigh pain? Yes ___ No ___

Do you have buttock pain or pain down the back of your leg? Yes ___ No ___

Do you have weakness/numbness of the affected leg? Yes ___ No ___

Do you have a history of back pain, injuries to your back or back surgery? Yes ___ No ___

Describe and give dates: _____

Treatments you have tried for this problem:

Physical Therapy Yes ___ No ___

Injections Yes ___ No ___

Surgery Yes ___ No ___

Medications Yes ___ No ___

List : _____

Physician Signature: _____ Date: _____

HIP