

# Hip Pain Questionnaire

Name \_\_\_\_\_

Which hip is bothering you?                      Left                      Right                      Both

Did your hip pain start with a specific injury?                      Yes                      No  
If yes:              Date of injury: \_\_\_\_\_

Mechanism of injury: \_\_\_\_\_

Is the injury work related:                      Yes                      No

Did your hip pain start with a particular activity?                      Yes                      No  
If yes, what activity started the pain? \_\_\_\_\_

If there was no injury, when did the pain start? \_\_\_\_\_

What part of your hip hurts?      Front                      Outside                      Back                      Deep inside

What are your primary sports and/or activities? \_\_\_\_\_

How would you describe your pain? (constant, intermittent, mild, moderate, severe, etc.)  
\_\_\_\_\_

Does your pain radiate down your leg?                      Yes                      No

Do any of the following increase your hip pain?  
Prolonged walking:                      Yes      Minimally      No  
Prolonged standing:                      Yes      Minimally      No  
Running:                      Yes      Minimally      No  
Going up or down stairs:                      Yes      Minimally      No  
Kneeling or squatting:                      Yes      Minimally      No  
Laying on your affected hip:                      Yes      Minimally      No  
Is there anything else that increases your pain? \_\_\_\_\_

Do any of the following decrease your pain?  
Rest:                      Yes      Minimally      No  
Ice:                      Yes      Minimally      No  
Heat:                      Yes      Minimally      No  
Over the counter medicines (Tylenol/Advil):                      Yes      Minimally      No  
Prescription pain medicines:                      Yes      Minimally      No  
Is there anything else that decreases your pain? \_\_\_\_\_

Do you have any of the following symptoms?

|  |     |    |
|--|-----|----|
| Clicking or catching of your hip:      | Yes | No |
| Back pain:                             | Yes | No |
| Numbness or tingling in your leg:      | Yes | No |
| Pain at night:                         | Yes | No |
| Difficulty putting shoes/socks on/off: | Yes | No |

Are there any other symptoms regarding your hip? \_\_\_\_\_

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Have you had any prior surgery to your hip(s)? Yes No

If yes, what type of surgery did you have and when did you have the surgery?

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Have you had any prior treatment for your hip pain such as:

|                       |     |    |
|-----------------------|-----|----|
| Cortisone injections: | Yes | No |
| Physical therapy:     | Yes | No |

Do you use any ambulatory aids (cane, crutches, walker) Yes No

In general do you think your hip pain is:

|                                 |     |    |
|---------------------------------|-----|----|
| Getting better?                 | Yes | No |
| Getting worse?                  | Yes | No |
| Staying the same/not improving? | Yes | No |

Have you had any x-rays taken of your hip(s)? Yes No

If yes: Date of x-ray: \_\_\_\_\_  
X-ray facility: \_\_\_\_\_

Have you had an MRI of your hip(s)? Yes No

If yes: Date of MRI: \_\_\_\_\_  
MRI facility: \_\_\_\_\_

Is there anything else we need to know about your hip pain?

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Thank you for filling out this form