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? _____

_____

_____

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?

_____

_____

_____

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?

_____

_____

_____

Thank you for filling out this form