

# HIP

Was this an injury or did it occur over time? \_\_\_\_\_

How long have you had this problem or what was the date of your injury? \_\_\_\_\_

Where on your body do you have the problem? \_\_\_\_\_

If an injury, describe how it occurred: \_\_\_\_\_

Have you had this problem before? Yes / No

If yes, how was it treated? \_\_\_\_\_

**Rate your pain:** No Pain 1 2 3 4 5 6 7 8 9 10 Absolute Pain

**Describe your pain (circle all that apply):**

- |                      |                      |                |              |
|----------------------|----------------------|----------------|--------------|
| Sharp                | Aching               | Stabbing       | Dull         |
| Constant Burn        | Come and go          | Pins & needles | Electric     |
| Explosive            | Unrelenting          | Throbbing      | Other: _____ |
| Constant             | Intermittent         | Chronic        | _____        |
| Getting better       | Getting worse        | Unchanged      |              |
| Worse in the morning | Worse in the evening | Worse at night |              |

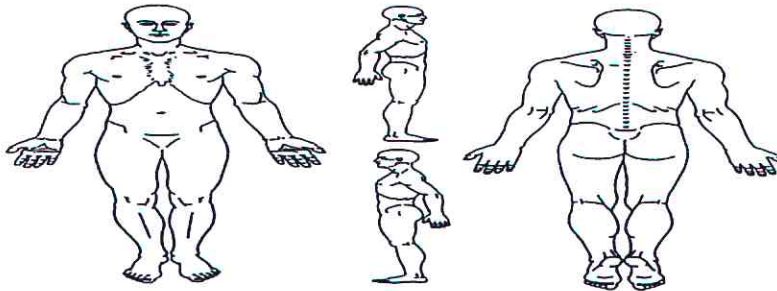
What makes your pain **worse**? \_\_\_\_\_

What makes your pain **better**? \_\_\_\_\_

Medications used for this problem: \_\_\_\_\_

Have you had any tests for this problem? MRI / Bone Scan / X-ray / Other \_\_\_\_\_

**Please indicate the location of your pain with an X:**



Do you have numbness or tingling? Yes / No If yes, where? \_\_\_\_\_

Do you have swelling? Yes / No If yes, where? \_\_\_\_\_

Have you had instability or dislocations? Yes / No

Do you have popping / catching / grinding?

Do you have back pain? Yes / No

Have you had any hip surgery? Yes / No

Where would you say your pain is? Groin / Buttock / Lateral (directly over the outside)

Do you have any other problems not previously described? Yes / No If yes, please describe: \_\_\_\_\_

Referring Physician: \_\_\_\_\_

Other Physician(s) you have seen for this problem: \_\_\_\_\_

Date(s) of work/school missed for this problem: \_\_\_\_\_

Is there an attorney involved with this problem? Yes / No If yes, please provide additional information: \_\_\_\_\_

Patient Name (*print*): \_\_\_\_\_ Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_