

# HIP QUESTIONNAIRE

## Advanced Sportsmedicine Center

1. FULL NAME: \_\_\_\_\_ AGE: \_\_\_\_\_ TODAY'S DATE: \_\_\_\_/\_\_\_\_/\_\_\_\_

2. Which hip bothers you? RIGHT  LEFT  BOTH

3. When was the **first time** you ever had hip symptoms? \_\_\_\_\_

4. When did your **present** hip problem begin? \_\_\_\_\_ How did it occur? \_\_\_\_\_

5. How far or how long can you walk without stopping because of hip symptoms? \_\_\_\_\_ Hours \_\_\_\_\_ Miles Unlimited

6. Have you had prior **right** hip injuries? YES  NO  If so, when & what? \_\_\_\_\_

7. Have you had prior **left** hip injuries? YES  NO  If so, when & what? \_\_\_\_\_

8. What part of your hip hurts? LATERAL (Outer part)  GROIN  BUTTOCK AREA  LUMBAR SPINE AREA

9. Describe the type of pain you have: CONSTANT  INTERMITTENT  SHARP  DULL  STABBING   
BURNING  ACHING

10. Do you have pain while trying to sleep at night? YES  NO

11. What causes hip pain? STANDING  WALKING  SITTING  LAYING  NONE  OTHER \_\_\_\_\_

12. My hip pain is now getting: WORSE  BETTER  STAYING THE SAME

13. My hip: POPS  LOCKS/CATCHES  GIVES OUT  DOES NONE OF THESE

14. My hip/buttocks/leg(s) have: LOSS OF SENSATION  TINGLING  NONE OF THESE

15. Are activities of daily living limited? YES  NO

If so, please list activities UNABLE to perform: \_\_\_\_\_

16. Have you had hip X-rays? YES  NO  If so, when & where? \_\_\_\_\_

17. Have you had a hip MRI? YES  NO  If so, when & where? \_\_\_\_\_

18. Has a doctor evaluated your hip? YES  NO  If so, whom? \_\_\_\_\_

19. Check any hip treatments you have tried before today:

ICE  HEAT  REST  CRUTCHES/CANE/WALKER  DECREASED ACTIVITIES   
HOME REHAB/EXERCISES  INJECTIONS  PHYSICAL THERAPY  GLUCOSAMINE   
CHONDROITIN  MSM  HERBAL REMEDIES   
HIP MEDICATIONS  (Please list) \_\_\_\_\_

WHICH TREATMENTS HAVE HELPED? \_\_\_\_\_

WHICH TREATMENTS HAVE WORSENERD YOUR CONDITION? \_\_\_\_\_