

HIP _____ RIGHT _____ LEFT _____ DATE: _____

Name: _____ Age _____ Height _____ Weight _____

Affected for: _____ days _____ months _____ years Injury Date _____ OR

Gradual Onset _____ Work Injury? Yes No Accident? Yes No Auto? Other?

How were you injured? _____ N/A

Pain: Rate your discomfortNone=0 | 2 3 4 5 6 7 8 9 10=Severe
Quality and Duration of the Pain: _____ Sharp _____ Dull _____ Burning _____ Throbbing
_____ Electric shocks _____ Constant _____ Intermittent (on and off)

In the past few days/weeks the pain has _____ increased _____ decreased _____ stayed the same

Where do your symptoms occur? _____ Groin _____ Side of Hip _____ Buttocks
_____ Front of thigh to knee _____ Side of thigh to knee _____ Below the knee

When do your symptoms occur? _____ Walking _____ Running _____ Using stairs
_____ Rising from chair _____ During exercise _____ After exercise
_____ At work _____ After work _____ At night _____ In the morning Other: (describe)

If these symptoms occur (Yes) please describe when or where. If not, indicate "No"

Stiffness No Yes _____
Numbness No Yes _____
Swelling No Yes _____
Locking No Yes _____
Catching No Yes _____
Giving way No Yes _____
Weakness No Yes _____

Difficulty walking? Distance you can walk without pain or stopping to rest _____ block(s)

Losing range of motion? Yes No > Can touch foot? Yes No > Losing leg length? Yes No

Do you use supports to walk? None Cane 2 Canes Crutch 2 Crutches Walker

Can you walk stairs? No Yes _____ Normally or _____ One at a time

Can you get out of a chair? No Yes _____ Normally or _____ Push with hands

Have you had any other treatment for this problem? (i.e. injections, glucosamine, etc.)
No Yes (describe) _____

What improves your symptoms? N/A Medication (list) _____
_____ Rest _____ Physical therapy _____ Heat _____ Ice _____ Brace/bandage _____ Exercise

Reviewed by: _____ Neal L. Rockowitz, M.D. rev 10/07