

Hip Pain Questionnaire

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

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

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

