

HIP PAIN EVALUATION FORM

Name: _____ Chart # _____ Date: _____

Please answer the following questions as they pertain to your hip:

- PAIN:**
- None: able to ignore it
 - Slight: occasional, no compromise to activity
 - Mild: no effect on ordinary activity; pain after usual activity; use aspirin/ibuprofen/Tylenol
 - Moderate: tolerable, make concessions to activity, occasional narcotic
 - Marked: serious limitations
 - Totally disabled

FUNCTION: Gait

Limp

- None
- Slight
- Moderate
- Severe
- Unable to walk

Support

- None
- Cane for long walks
- Cane all the time
- 2 canes
- Crutch
- 2 crutches
- Unable to walk

Distance Walked

- Unlimited
- 6 blocks
- 2-3 blocks
- Indoors only
- Bed and chair

FUNCTIONAL ACTIVITIES

Stairs

- Can go up / down normally
- Can go up / down normally w/ banister
- Can go up/down with any method
- Not able to use stairs

Socks / Shoes

- With ease
- With difficulty
- Unable

Sitting

- Any chair, 1 hour
- Any chair, 1/2 hour
- Unable to sit 1/2 in any chair

Public Transportation

- Able to enter public transportation
- Unable to use public transportation

1. How far can you walk prior to pain? _____
2. Do you avoid physical activity such as long distances, shopping, going up stairs? Yes No
3. Do you have a regular exercise program? Yes No
4. What is your amount of pain at rest? Least = 1 2 3 4 5 6 7 8 9 10 = Max
5. Pain during or immediately after activity? Least = 1 2 3 4 5 6 7 8 9 10 = Max
6. Where is your pain located? Back Buttocks Down the leg Groin Thigh
7. Does your pain radiate to other places? Down Thigh Leg Backward Other
8. Have you had previous hip injuries? _____
9. Previous treatments? Physical therapy Steroid injections Synvisc or hyalgan injections
 Anti-inflammatory medications Chondroitin / glucosamine
10. Previous hip surgeries? _____
11. How does your hip pain limit your daily functions? _____

