

PATIENT HISTORY QUESTIONNAIRE

HIP

NAME: _____ AGE: _____ TODAY'S DATE: _____

Which HIP is painful? _____ How long has it been painful? _____

Was there an injury to your HIP(S)? _____ If yes, please describe: _____

Where is your pain located? (front, back, top, medial, lateral, etc.): _____

Describe your pain (dull, sharp, constant, aching, etc.): _____

What are some of your symptoms?

____ Swelling/Fluid

____ Weakness

____ Popping/Clicking

____ Bruising

____ Night Pain

____ Locking

____ Instability

____ Numbness/Tingling

____ Stiffness

____ Limited Range of Motion

____ Referred/Traveling Pain

____ Buckling/Giving Out

Pain Level: 1 2 3 4 5 6 7 8 9 10 (please circle)
Least Most

PREVIOUS TREATMENT:

1. Do you have any X-RAY's of your HIP(S)? _____

If yes, when and where were they done & who was the ordering physician? _____

2. Do you have an MRI of your HIP(S)? _____

If yes, when and at what facility did you have the MRI? _____

3. Are you taking medications specific to your HIP pain? _____

If yes, which medication(s)? _____

4. Have you had previous treatment by another Doctor, any Physical Therapist, Acupuncturist, or
Chiropractic treatment for your HIP(S)? _____

If yes, by whom & when? _____

5. Have you had any surgery on your HIP(S)? _____

If yes, by whom & when? _____

6. Is a legal case involved with this injury? _____ Is this a work related injury? _____

**IF YOU ANSWERED YES TO EITHER ONE OF THE QUESTIONS IN #6, PLEASE FILL OUT
THE WORK RELATED INJURY FORM.**

THANK YOU