



**HIP INITIAL HISTORY FORM**

NAME \_\_\_\_\_ DATE \_\_\_\_\_ AGE \_\_\_\_\_

Which hip hurts?  Right  Left  Both

If both hips hurt, which one is worse?  Right  Left  Equal

How long has the pain been present? \_\_\_\_\_

Did the pain start:  Suddenly  Gradually  
Date: \_\_\_\_\_

Did you suffer an injury to the hip?  Yes  No

If yes, please explain: \_\_\_\_\_

Where is your hip pain? (/ all that apply)  Groin  Behind hip  Side of hip

Is one leg shorter?  Yes  No If yes, which leg is shorter:  Right  Left

Please describe your activity level: (/ only one)

- Strenuous – running sports
- Moderate – manual work, doubles tennis, skiing
- Light – walking, stationary cycle
- Walk few steps only, mostly sitting

Do you walk: (/ one)

- Normally
- With a limp
- With a cane
- With crutches
- With a walker

Can you walk: (/ one)

- Unable to walk
- Less than one block
- 1 – 5 blocks
- 5 – 10 blocks
- Unlimited

Have you had any of the following treatment for your hip?

Surgeries  Yes  No When? \_\_\_\_\_  
Injections  Yes  No When? \_\_\_\_\_  
Physical Therapy  Yes  No When? \_\_\_\_\_  
Anti-inflammatory meds  Yes  No Name? \_\_\_\_\_

