WESTERN ORTHOPAEDICS
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Brian J. White, MD
Hip Intake Form

Name:_____
MR#:_____
Date:_____

Do you have pain with any of the following?

1.	Long Sitting?	Yes	No
2.	Long Driving or Travel?	Yes	No
3.	Cycling?	Yes	No
4.	Putting on shoes and socks?	Yes	No
5.	Walking?	Yes	No
6.	Running?	Yes	No
7.	Pivoting/Twisting?	Yes	No
8.	Squatting?	Yes	No

Do you have any of the following mechanical symptoms? (Please circle symptoms if Yes)

Giving way - Giving out - Catching - Painful popping - Non-painful popping

Pelvic Floor Questions:

1.	Do you have pain or discomfort with intercourse?	Yes	No
2.	Do you have bladder problems such as incontinence or urinary urgency?	Yes	No
3.	Do you have difficulty or pain with bowel movements?	Yes	No
4.	In addition to your hip pain do you have a deep pain near the sit bone area?	Yes	No
5.	Females: Have you had children?	Yes	No

Please circle all the areas where you are having pain?

Groin - Bikini line - Side of hip - Buttock - Front of thigh Other: _____

Have you had any injections?

1. Into the side of hip or bursa? Yes No
   If yes, how long was it helpful? _____
   What percentage of your symptoms did it take away? _____%
2. Into the hip joint by x-ray? Yes No
   If yes, how long was it helpful? _____
3. What percentage of your symptoms did it take away? _____%

Medications

1. Have you taken any anti-inflammatories or Tylenol? Yes No
2. How long, specifically, have you been taking them (not just as needed)? _____
3. Did you develop any issues/side effects from taking it? Yes No

   If yes, please explain: _____

   _____
4. Please indicate what dosage and frequency: _____

_____

Physical Therapy?

1. Have you done Physical Therapy for this? Yes No
2. Where did you go? _____
3. How long did you attend? _____
4. Did it completely fix the problem? Yes No
5. Have you done massage or chiropractic work? Yes No

How are you presently feeling?

1. My pain consistently negatively impacts my mood and overall life satisfaction. Yes No
2. Losing my identity as an athlete (someone who is active) and not being able to exercise has been really challenging for me. Yes No
3. I am struggling with not knowing how to relieve my stress now that I cannot exercise like I used to. Yes No
4. I am unclear how to accept my new "disability status" even if it may be temporary. Yes No
5. I fear the uncertainty of what my future holds, wondering if this is my "new normal" and whether I will ever be without pain again. Yes No

Practitioner's notes:

Practitioner's initials and date: _____/_____