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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 symptoms:

1. Giving way or giving out? Yes No
2. Catching sensation? Yes No
3. Painful Popping? Yes No
4. Popping that is <u>not</u> Painful? Yes No

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 or 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? ___________________________
   What percentage of your symptoms did it take away? _______

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

Practitioner's initials and date: __________________