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 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: _____