PT NAME______________________

HISTORY FORM/ HIP

Please circle below the answers to the following questions

Right hip/ Left hip How long have you had this problem?__________________

Where does your hip hurt (Back / Buttock / Lateral Hip / Groin Pain / Thigh Pain)_______

Does the pain move anywhere else? yes / no Where?___________________________

Describe the Pain burning / sharp / dull / aching / stabbing ______________________

Is the pain constant / come and go?____

Does anything make the pain worse? Sitting / standing / lying down _______________

Does anything make the pain better? Sitting / standing / lying down_______________

Please add any additional information below that would be important for the Doctor to know below

____

____

____

____