Name: ____ **Date of Birth:** ________________

Hip Intake Form

Subjective ____

____

____

____

When did the problem start? _________________

How often do you have pain? ☐Constant ☐ Many times every day ☐ Many times every week ☐ Other _______

Any other symptoms? Please check all that apply: ☐ Numbness ☐ Tingling ☐ Pins and needles

Any history of low back problems? ☐Yes ☐ No Any history of sciatica? ☐Yes ☐ No

Any pains radiate beyond your knee? ☐ Yes ☐ No Night pain? ☐Yes ☐ No

What makes the problem worse?

____

____

What makes the problem better?

____

____

What diagnostic studies have been done? Please circle and date the study

CT scan _________ Xray _________

MRI _________ Bone scan _________

Vascular Studies ________ Other: _____________________

Which pain medications have you taken for this problem? Please check all that apply

☐Naproxen (Alleve): _____ number of pills per day ☐Vicodin: _____ number of pills per day

☐Ibuprofen (Advil, Motrin): _____ number of pills per day ☐Oxycodone or oxycontin: _____ number of pills per day

☐Celebrex: _____ number of pills per day ☐ Other ______________: _____ number of pills per day

Have you participated in physical therapy? ______ number of months

Have you had injections? ☐Yes ☐ No Number of injections: _______

How much did it help on the day of the injection? ☐None ☐ A little ☐ 50% ☐ A lot ☐ Completely

For how long did it help? ______ number of months

Any other treatments? Please list:

____