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

_____

_____

_____

_____