PRO SPORT ORTHOPEDICS
EMPOWERING HUMAN PERFORMANCE

NEW HIP PATIENT INTAKE FORM

Full Name: _____ **Date:** _____

What is your chief complaint/reason for the visit?_____

Occupation/Employer:_____

Which hip would you like to discuss today?(check one) ☐ Right ☐ Left ☐ Bilateral

Are your symptoms: (select one) ☐ New ☐ Recurrent ☐ Chronic

Did your symptoms begin: (select one option) ☐ Insidiously ☐ Suddenly

Where were you when your symptoms first began? (select one option)

☐ Home ☐ Skilled nursing facility ☐ Work ☐ School ☐ The gym ☐ While ☐ traveling
☐ Other:_____

When did your symptoms first occur? (provide a date or the most accurate time frame):_____

Describe what caused your symptoms?_____

_____

_____

How have your symptoms evolved since the onset? (select all that apply)

☐ Intermittent
☐ Constant
☐ Mildly progressive
☐ Moderately progressive
☐ Severely progressive
☐ Improving gradually
☐ Improving quickly
☐ Improving and have completely resolved

What symptoms are you experiencing? (select all that apply)

☐ Pain at rest
☐ Pain with normal daily activities
☐ Mechanical sensations (e.g. catching, locking)
☐ Audible sounds (e.g. clicking, popping)
☐ Hip instability
☐ Lack of trust or confidence with the hip
☐ Stiffness
☐ Weakness
☐ Fatigue
☐ Hypersensitivity
☐ Deficient sensation
☐ Numbness (complete absence of sensation)

Have you had any prior injuries, dislocations, or surgeries involving this hip?

☐ No
☐ Yes, please describe:_____

If you feel hip pain, please describe it (select all that apply):

☐ Shock-like ☐ Aching ☐ Shooting ☐ Dull
☐ Sharp ☐ Throbbing ☐ Deep

How severe is the pain on a scale from 1 (minimal) to 10 (most severe)?_____

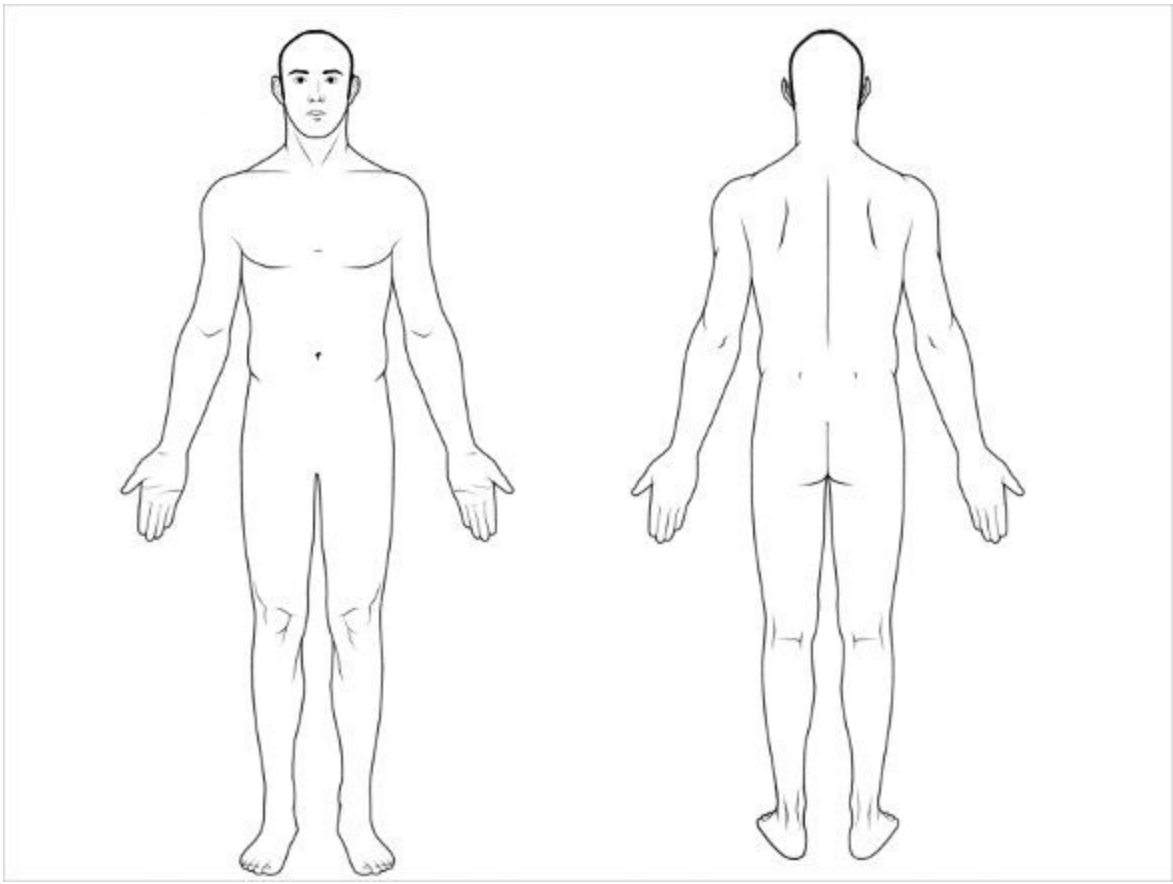
Nature of pain (select all that apply): ☐ Localized ☐ Diffuse

Please use the diagram below to indicate where you feel symptoms.

Use the following key to indicate the different type of symptoms

Stabbing pain: xxxxxxx Burning pain: ///////////////

Deep Ache: 0000000 Pins and Needles: zzzzzzz



Does your hip pain radiate? (select all that apply)

☐ No

☐ Pain radiating to the lower back

☐ Pain radiating down the lateral thigh/leg

☐Pain radiating down the anterior thigh/leg

☐ Pain radiating to the buttock

☐ Pain radiating down the posterior thigh/leg

☐ Pain radiating down the anterior thigh to the knee

What aggravates your symptoms? (select all that apply)

☐ Standing

☐ Squatting/kneeling

☐ Running

☐ Jumping

☐ Descending stairs

☐ Cycling

☐ Performing typical job-related tasks

☐ Sleeping

☐ Sitting

☐ Walking

☐ Pivoting or changing direction

☐ Ascending stairs

☐ Carrying loads >20 pounds

☐ Exercising

☐ Working around the home

☐ Nothing

What improves your symptoms? (select all that apply)

☐ Rest ☐ Cold therapy
☐ Heat therapy ☐ Physical therapy
☐ Chiropractic treatments ☐ Massage
☐ Stretching ☐ NSAIDs
☐ Narcotics ☐ Non-narcotic pain medications
☐ Corticosteroid injections ☐ Exercise
☐ Nothing ☐ Other:_____

Do you have any numbness or tingling in the same extremity? ☐ Yes ☐ No

What is your goal of treatment? (select all that apply)

☐ Decrease pain ☐ Increase strength
☐ Increase range of motion ☐ Increase function
☐ Prevent further decline in function ☐ Maintain employment
☐ Avoid surgery ☐ Return to pre-injury status

What treatments have you attempted? (select all that apply)

☐ None ☐ Rest
☐ Cold therapy ☐ Heat therapy
☐ Over-the-counter pain medications ☐ Anti-inflammatory medications/NSAIDs
☐ Narcotics ☐ Non-narcotic pain medications
☐ Self-directed home exercise program ☐ Other:_____

Have you attempted any provider-directed rehabilitation or therapy program? (select one option)

☐ No ☐ Yes, but for less than 6 weeks within the past 3 months
☐ Yes, for greater than 6 weeks within the past 3 months

If you have had provider-directed rehab:

What type of rehab or therapy was it? (select all that apply)

☐ Physical therapy ☐ Chiropractic sports rehab ☐ Provider-directed home exercise program

What was your response to the rehab? (select one option)

☐ No benefit ☐ Mild benefit, but symptoms remain ☐ Moderate benefit, but symptoms remain
☐ Significant benefit, but symptoms remain ☐ All symptoms have resolved

Have you had any hip injections? ☐ No ☐ Yes

The date of injection_____
The injection location (into the hip joint, into a bursa, other area)_____
The type of injection: (corticosteroid, hyaluronic acid, anti-inflammatory, PRP, bone marrow aspirate concentrate, other, unknown) _____
The maximal percentage of pain (0-100%) that was improved
The duration of the improvement in pain

Date of injection:_____ location:_____ Type:_____ % Pain improved:____ Duration of relief:_____
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What imaging studies of your hip have already been obtained?

☐ None
☐ Radiographs greater than 3 months ago
☐ MRI greater than 3 months ago
☐ CT greater than 3 months ago
☐ Bone scan greater than 3 months ago
☐ Radiographs within the past 3 months
☐ MRI within the past 3 months
☐ CT within the past 3 months
☐ Bone scan within the past 3 months

Review Of Systems: Please select all symptoms that are currently present

Constitutional: ☐ Fever ☐ Chills ☐ Night sweats

HENT: ☐ Facial swelling ☐ Nosebleeds

Eyes: ☐ Visual disturbance

Cardiovascular: ☐ Chest pain ☐ Leg swelling

Respiratory: ☐ Shortness of breath ☐ Chest tightness

Gastrointestinal: ☐ Blood in stool ☐ Constipation ☐ Diarrhea

Genitourinary: ☐ Difficulty urinating ☐ Dysuria (pain when urinating) ☐ Flank pain ☐ Blood in urine

Musculoskeletal:

☐ Joint pain ☐ Back pain ☐ Difficulty walking ☐ Joint swelling ☐ Muscle pain ☐ Neck pain

Neurological: ☐ Dizziness ☐ Headaches ☐ Numbness ☐ Limb/muscle weakness

Hematologic: ☐ Bruising ☐ Easy bleeding

Psychological: ☐ Confusion ☐ Nervous/anxious ☐ Self-inflicted injury

Skin: ☐ Changes in skin color ☐ Rashes/lesions ☐ Open wounds

Allergic/Immunologic: ☐ Allergies to new medications/foods/clothing ☐ Hay fever

Endocrine: ☐ Increased urination or thirst ☐ Palpitations ☐ Weight loss or weight gain

Past Medical History:

☐ Diabetes
☐ DVT/PE/Blood Clots
☐ Emphysema/COPD
☐ Epilepsy
☐ Fractures
☐ Glaucoma
☐ Goiter
☐ Gonorrhea
☐ Gout
☐ Heart Disease
☐ Hepatitis
☐ Hernia
☐ Liver Disease
☐ Malignant Hyperthermia
☐ Measles
☐ Migraine/Headache
☐ Miscarriage
☐ Mononucleosis
☐ Multiple Sclerosis
☐ Mumps
☐ Osteoporosis
☐ Pacemaker
☐ Parkinson's Disease
☐ Peripheral Vascular Disease
☐ Psychiatric Care
☐ Rheumatoid Arthritis
☐ Rheumatic Fever
☐ Scarlet Fever
☐ S.T.D.
☐ Stroke
☐ Substance Abuse
☐ Suicide Attempt
☐ Thyroid Problems
☐ Tonsillitis
☐ Tuberculosis
☐ Tumors/Growths

☐ Herniated Disk
☐ Herpes
☐ High Blood Pressure
☐ High Cholesterol
☐ Kidney Disease
☐ Pinched Nerve
☐ Pneumonia
☐ Polio
☐ Prostate Problem
☐ Prosthesis
☐ Typhoid Fever
☐ Ulcers
☐ Vaginal Infection
☐ Whooping Cough
☐ Other:
☐ No significant medical history

Past Surgical History:

☐ Appendectomy
☐ Biopsy:
☐ Brain Surgery
☐ Breast Surgery
☐ Heart Bypass (CABG)
☐ Gall Bladder Removal
☐ Colon Surgery
☐ Cosmetic Surgery
☐ Eye Surgery
☐ Fracture Surgery
☐ Gastric Bypass/Banding
☐ Hernia Repair
☐ Hip Arthroscopy
☐ Hip Replacement Surgery
☐ Hysterectomy
☐ Knee Arthroscopy
☐ Knee Replacement Surgery
☐ Kidney Stone Surgery (Lithotripsy)
☐ Ovary Removal
☐ Prostate Surgery
☐ Spine Surgery
☐ Tonsil/Adenoid Surgery
☐ Valve Replacement Surgery
☐ Vasectomy
☐ Other:
☐ None

Family Medical History:

Please indicate any major conditions/illnesses that your immediate family members have had:

Relative	Condition and description	Living?	If deceased, at what age?
Mother		□ Y □ N	
Father		□ Y □ N	
Sibling		□ Y □ N	
Other:		□ Y □ N	

Social History:

Marital status:

☐ Single ☐ Married ☐ Divorced ☐ Widowed Number of children:_____

Alcohol consumption: ☐ None ☐ Yes

Glasses of wine per week:_____ ☐ Cans of beer per week:_____ ☐ Shots of liquor per week:_____

Tobacco use: ☐ None ☐ Yes

Current cigarette use: ____ packs per day for ____ years

Former cigarette use: ____ packs per day for ____ years, quite date: _____

Other nicotine-containing products:_____

Allergies: Please allergies and reactions

Allergies: _____ Reaction: _____
Allergies: _____ Reaction: _____
Allergies: _____ Reaction: _____
Allergies: _____ Reaction: _____
Allergies: _____ Reaction: _____
Allergies: _____ Reaction: _____

Medications:

Medication: _____ Dose: _____ Frequency: _____

Medication: _____ Dose: _____ Frequency: _____

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