INITIAL HIP EVALUATION FORM

Note: This is a confidential record and will be kept in your doctor's office. Information contained here will not be released to anyone without your authorization to do so.

TODAY'S DATE ____/____/____ FAMILY DOCTOR _____

NAME_____ DATE OF BIRTH ____ /____ /____

SOCIAL SECURITY #_____

CHIEF COMPLAINT - What is the main reason for your visit today? (Describe your problem in detail)

_____

_____

Were you referred to us by another health care professional? (If yes please state name) _____

Occupation/Employer: _____

Is this condition work related: Yes No If yes, date of injury: _____

(Please circle/complete answers below)
Date symptoms began: _____

Was it related to an injury? Yes No
If so, describe injury: _____

Has it been getting better or worse? (circle)

Have you seen other physicians for this problem? Yes No
If so, who? _____

What treatments have you had for this problem?
Physical Therapy Injections
Chiropractic Surgery
Other_____

Location of the problem:
Left Right Both
Groin Outside of hip Buttock

Symptoms are:
Mild Moderate Severe

What activities make it better?
Rest Stretching
Ice Heat

What activities make it worse?
Walking Work Sports
Other_____

Office use only
Height _____ Weight_____ Temp _____

HISTORY OF PRESENT ILLNESS:
(OFFICE USE ONLY)

REVIEW OF SYSTEMS:
Do you have any of the following symptoms? (Circle Yes or No)

Chest pain	Y	N	Bloody Urine	Y	N
Indigestion/heartburn	Y	N	Kidney problems	Y	N
Fever or chills	Y	N	Urinary tract infection	Y	N
Sinus problems	Y	N	Blood clotting problem	Y	N
Shortness of breath	Y	N	Sore throat	Y	N
Bloody cough or stools	Y	N	Back pain	Y	N
Dark, tarry stools	Y	N	Neck pain	Y	N

PAST MEDICAL & SOCIAL HISTORY:

List all chronic illnesses/conditions:
(Example: diabetes, heart disease,
high blood pressure, etc.)

_____ _____ _____
_____ _____ _____
_____ _____ _____

List any past surgeries

Surgery	Approximate Date

Are you on any medications? Y N (If yes, list all.)

_____ _____ _____
_____ _____ _____
_____ _____ _____
_____ _____ _____

Do you have any medication allergies? Y N (If yes, list all.)

_____ _____ _____
_____ _____ _____
_____ _____ _____

Do you smoke? Y N
If yes, how much? _____

Do you drink alcohol? Y N
If yes, how much? _____