Do you have pain with any of the following:

1. Long Sitting?  Yes  No
2. Long Driving or Travel?  Yes  No
3. Cycling?  Yes  No
4. Putting on shoes and socks?  Yes  No
5. Walking?  Yes  No
6. Running?  Yes  No
7. Pivoting/Twisting?  Yes  No
8. Squatting?  Yes  No

Do you have any of the following symptoms:

1. Giving way or giving out?  Yes  No
2. Catching sensation?  Yes  No
3. Painful Popping?  Yes  No
4. Popping that is not Painful?  Yes  No

Pelvic Floor Questions:

1. Do you have pain or discomfort with intercourse?  Yes  No
2. Do you have bladder problems such as incontinence or urinary urgency?  Yes  No
3. Do you have difficulty or pain with bowel movements?  Yes  No
4. In addition to your hip pain do you have a deep pain near the sit bone area?  Yes  No
5. Females: Have you had children?  Yes  No

Please circle all the areas where you are having pain:

Groin or Bikini line  Side of hip  Buttock  Front of thigh  Other:  

Have you had any injections?

1. Into the side of hip or bursa?  Yes  No
   If yes, how long was it helpful?  
   What percentage of your symptoms did it take away?  

2. Into the hip joint by x-ray?  Yes  No
   If yes, how long was it helpful?  
   What percentage of your symptoms did it take away?  

Physical Therapy?

1. Have you done Physical Therapy for this?  Yes  No
2. Where did you go?  
3. How long did you attend?  
4. Did it completely fix the problem?  Yes  No
5. Have you done massage or chiropractic work?  Yes  No

Practitioner’s initials and date:  