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Brian J. White, MD
Hip Intake Form

Name: _____
MR#: _____
Date: _____

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 mechanical symptoms? (Please circle symptoms if Yes)

Giving way - Giving out - Catching - Painful popping - Non-painful popping

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 - 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? _____ | | |
| 3. What percentage of your symptoms did it take away? _____% | | |

Medications

- 1. Have you taken any anti-inflammatories or Tylenol? Yes No
- 2. How long, specifically, have you been taking them (not just as needed)? _____
- 3. Did you develop any issues/side effects from taking it? Yes No
If yes, please explain: _____

- 4. Please indicate what dosage and frequency: _____

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

How are you presently feeling?

- 1. My pain consistently negatively impacts my mood and overall life satisfaction. Yes No
- 2. Losing my identity as an athlete (someone who is active) and not being able to exercise has been really challenging for me. Yes No
- 3. I am struggling with not knowing how to relieve my stress now that I cannot exercise like I used to. Yes No
- 4. I am unclear how to accept my new “disability status” even if it may be temporary. Yes No
- 5. I fear the uncertainty of what my future holds, wondering if this is my “new normal” and whether I will ever be without pain again. Yes No

Practitioner’s notes:

Practitioner’s initials and date: _____ / _____