HIP CLINIC
QUESTIONNAIRE

Patient Name: _____

Guardian Name: _____

Referring Physician(s): _____

DOB: _____

Phone number(s): Home: _____ Cell: _____ Fax: _____

Email : _____

Address (If email or fax not available):

_____

1) Have you been seen by an orthopedic surgeon? Who? Where

_____

_____

2) Are you experiencing any pain? How Long? What is pain on scale of 1-10?

_____

_____

3) Is the hip pain you're being referred for related to a past injury?

_____

_____

4) Have you had any treatment or surgeries done in the past for this hip problem?

_____

_____

5) Have there been X-rays/MRI/or other imaging done? Date of x-rays?

_____

_____

Additional Notes:

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Created: June 1, 2010