Dr Matt Lyons

Date of Consultation:_____

HIP INJURY ASSESSMENT FORM

Name:_____

Height:_____

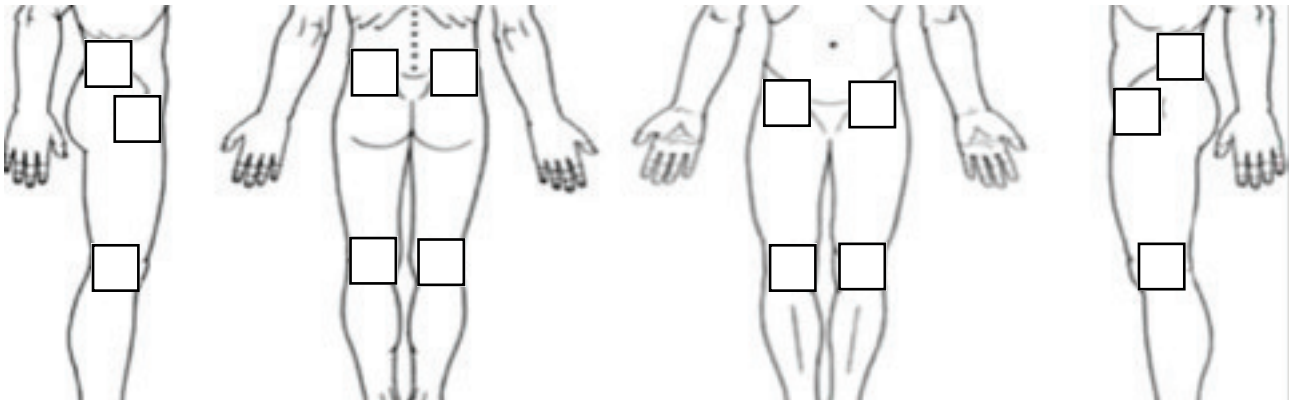
Occupation:_____

Weight:_____

Which hip is affected? (Please circle) RIGHT / LEFT

If both, which is worse? RIGHT / LEFT

Please mark on the image where pain is experienced?



How long has your hip been bothering you?_____

What are the main issues and restrictions you have experienced?_____

_____

What symptoms have troubled you in the past 2 weeks?

- Pain
- Grinding
- Difficulty putting on shoes/socks
- Difficulty going up stairs
- Difficulty sleeping
- Stiffness
- Catching
- Difficulty getting in/out of a car
- Difficulty going down stairs
- Other:_____

What treatments have you had for your hip?

- Pain killers
- Anti-Inflammatories
- Physiotherapy
- Surgery
- Injections
- Other:_____

If you have had previous surgery, please list surgeon, procedure and date of surgery:

_____

Have you injured your hip in the past? If yes, please describe:_____

_____

What activities do you wish to resume after your treatment?_____

_____

What are your expectations from todays consultation?_____

_____