Ortho Nebraska

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Hip Intake Form - Dr. Burt

Patient Name	Date of Birth	Height	Weight
Appointment Date	**Referring Physician**	**Family Physician**	**Pharmacy**

Are you a competive athlete? ○ Yes ○ No
If yes, list primary sport _____
Is this a Workmen's Compensation Claim? ○ Yes ○ No
Which hip is bothering you? ○ Left ○ Right ○ Both
How long has this bothered you? ___Days ___Weeks ___Months ___Years
Did you have a specific injury? ○ Yes ○ No
If yes, describe the injury _____
If yes, list date of injury _____
Are your symptoms? ○ Better ○ Worse ○ Same
Location of Pain ☐ Groin or bikini line ☐ Front of thigh ☐ Side of Hip ☐ Buttock
How would you describe your pain?
☐ Dull ☐ Burning ☐ Sharp/Shooting ☐ Stabbing ☐ Other _____
Rate your pain on a scale of 1 to 10, 10 being the worst: _____
Is your pain? ○ Constant ○ Intermittent
What makes your symptoms worse?
☐ Driving ☐ Prolonged Sitting ☐ Standing ☐ Walking ☐ Running ☐ Pivoting/twisting
☐ Exercise ☐ Rotational Movement ADLs ☐ Sleeping ☐ Putting shoes/socks on
Other _____
What makes your symptoms better? _____
Do you have any of the following symptoms?
☐ Giving way ☐ Catching/pinching sensation ☐ Painful popping ☐ Painless popping
Have you tried any of the following treatment?
Medications (over the counter and prescription): _____
Injection
☐ Bursa injection _____ Was it helpful? _____
☐ Intraarticular injection _____ Was it helpful? _____
Physical Therapy _____ Was it helpful? _____
Surgery _____ Was it helpful? _____
Have you had any of the following test? If yes, please indicate when and where:
Xrays: _____
MRI: _____
Please list any current medications, both over-the-counter and prescription:

_____

_____

Please list any medical allergies:

_____

_____

Did you receive the influenza vaccine this season? ○ Yes ○ No
Have you been discharged from a nursing facility, hospital or skilled rehabilitation facility in the last 30 days? ○ Yes ○ No