

		X-Ray
R	L	Finger: _____
R	L	Hand _____
R	L	Wrist (AP, Lat, Oblique)
R	L	Elbow (AP, Lat, Oblique)
R	L	Shoulder (AP, Grash, AX Scap Y)
R	L	Hip (<input type="checkbox"/> with AP Pelvis)
R	L	Knee (Stand AP, Lat Sunrise)
R	L	Ankle (AP, Lat, Mortise)
R	L	Foot (AP, Lat, Oblique)
		Other: _____

Hip Assessment

Patient's Name: _____ Occupation: _____

Involved Hip: **RIGHT** **LEFT** **BOTH** Was there an injury? **YES** **NO**

Date of Injury _____ Did the injury occur at work? **YES** **NO**

Describe what happened to your hip.

Primary Care Doctor's Name _____

Who Referred You To Us? _____

Circle problems with your hip.	
Location:	Outer (lateral) Front (anterior) Groin Area Other _____
Quality:	Aching Boring Pins/Needles Sharp Sore Stabbing Stinging Throbbing Other: _____
Severity:	Mild Moderate Severe
Rate the Pain:	(No pain) 0---1---2---3---4---5---6---7---8---9---10 (Severe pain)
Does the pain affect your sleep?	Yes No Do you have: Radiating pain Numbness Tingling
Functional Impairment:	Mild Mild-Moderate Moderate Severe/Disabling
Are you currently in pain?	Yes No When did it start? Days____ Weeks____ Months____ Years____
Aggravating Factors:	Climbing stairs Running Squatting Sports Other: _____
Relieving Factors:	Cold Heat Massage Other: _____
Previous Treatment:	Injections: Yes No Medications _____ OTC _____ Surgeries _____
Joint Symptoms:	Grinding Giving Away Instability Locking Looseness Loss of Motion Popping Swelling
	Tender to Touch Other _____

* Dr. Thompson and Dr. Galluch are investors in Ohio Valley Medical Center. At times they refer patients to Ohio Valley Medical Center in connection with their care and treatment.