GP THERAPY, LLC **D.B.A.**

GERMANTOWN PHYSICAL THERAPY

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Patient: ______________________________________ **Diagnosis:**___________________________________

Region: Hip

1. Describe your pain (sharp, dull, radiating, etc)____
2. When and how did it start?____
3. What makes it better? Worse?____
4. Have you had other treatment for this condition? If so, what kind?___________________________________
____
5. Rate your average pain intensity over the past week on the 0 to 10 scale with 10 being the worst pain imaginable. _____/10
6. Average number of times you wake each night due to **hip** pain. _____
7. Sitting tolerance is _____ minutes.
8. Driving tolerance is _____ minutes.
9. Standing tolerance is _____ minutes.
10. Walking tolerance is _____ minutes.

For questions 11 through 19, circle the number that best describes your level of difficulty with the following activities. 0 indicates no difficulty, whereas 10 indicates the inability to perform the activity at all.

	No Difficulty								Extreme Difficulty		
11. Stair climbing	0	1	2	3	4	5	6	7	8	9	10
12. Getting in/out of car	0	1	2	3	4	5	6	7	8	9	10
13. Coming to stand from sitting	0	1	2	3	4	5	6	7	8	9	10
14. Turning over in bed	0	1	2	3	4	5	6	7	8	9	10
15. Dressing (shoes, socks, pants, etc.)	0	1	2	3	4	5	6	7	8	9	10
16. Washing (feet, legs, etc.)	0	1	2	3	4	5	6	7	8	9	10
17. House cleaning	0	1	2	3	4	5	6	7	8	9	10
18. Traveling	0	1	2	3	4	5	6	7	8	9	10
19. Social life	0	1	2	3	4	5	6	7	8	9	10

20. What is your current occupation?____

21. Does your pain affect your occupation? If so, how?_______________________________________
____

22. Does your pain affect home life? If so, how?____
____

23. Does your pain affect your recreation/leisure/sports? If so, how? ____________________________
____

Patient's Signature: ____ Date: _____/_____/_____