



Patient Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

**Hip/Pelvis/Upper Leg Intake Survey**

**1. In general, would you say your health is:**

Excellent                  Very Good                  Good                  Fair                  Poor

**2. How much difficulty do you have standing for > 30 minutes?**

Unable to perform          A lot                          Some                  A little                  None

**3. How much difficulty do you have walking for >30 minutes?**

Unable to perform          A lot                          Some                  A little                  None

**4. How much difficulty do you have going up and down stairs?**

Unable to perform          A lot                          Some                  A little                  None

**5. How much difficulty do you have squatting or bending over?**

Unable to perform          A lot                          Some                  A little                  None

**6. How much difficulty do you have jogging?**

Unable to perform          A lot                          Some                  A little                  None

**7. Please indicate your pain range within the last week giving a score for the lowest and highest on the scale below.**

No pain 0          1          2          3          4          5          6          7          8          9          10 Worst pain ever