Ortho Nebraska

2725 South 144th Street, Suite #212
Omaha, NE 68144
phone: (402) 637-0800
fax: (402) 637-0808

# Hip Intake Form - Dr. Burt

| Patient Name | OrthoNebraska Physician | Referring Physician | Primary Care Physician |
|---|---|---|---|
| | | | |
| **Appointment Date** | **Height** | **Weight** | **Date of Birth** |
| | | | |

**Are you a competive athlete?** Yes No
If yes, list primary sport _____
**Is this a Workmen's Compensation Claim?** Yes No
Which side is bothering you? Left Right Both
**Did you sustain an injury to your hip?** Yes No
If yes, list date of injury _____
**Describe the injury** _____
**Duration of Symptoms** (Circle)
Days Weeks Months Years

**Do you have any pain with any of the following?**
1. Long Sitting? Yes No
2. Long Driving or Travel? Yes No
3. Cycling? Yes No
4. Putting on shoes and socks? Yes No
5. Walking? Yes No
6. Running? Yes No
7. Pivoting/Twisting? Yes No
8. Squatting? Yes No
9. Other, please describe _____

**Do you have any of the following symptoms?**
1. Giving way or giving out? Yes No
2. Catching sensation? Yes No
3. Painful popping? Yes No
4. Popping that is not painful? Yes No

**Pelvic Floor Questions**
1. Do you have pain or discomfort with intercourse? Yes No
2. Do you have bladder problems such as incontinence, urinary urgency? Yes No
3. Do you have difficulty or pain with bowel movements? Yes No
4. In addition to hip pain, do you have pain near the sit bone? Yes No
5. Females: have you had children?

**Please circle all areas where you are having pain**
Groin or bikini line Side of hip Buttock Front of high Other

**Have you had any injections?**
1. Into the side of hip or bursa? Yes No
   If yes, how long was it helpful? _____
   What percentage of your symptoms did it take away? _____
2. Into the side of hip or bursa? Yes No
   If yes, how long was it helpful? _____
   What percentage of your symptoms did it take away? _____

**Physical Therapy**
1. Have you done physical therapy for this? Yes No
2. Where did you go and for how long? _____
3. Did it completely fix the problem? Yes No
4. Have you done massage or chiropractic work? Yes No

**Have you taken any medications to help hip pain?** Yes No
If yes, please list _____
**Do you take any other medications prescribed/over-the-counter?** Yes No
If yes, please list _____
**If you are over the age of 65, have you had a pneumonia immunization?** Yes No
**Did you receive an influenza immunization this season?** Yes No
**Do you have any drug allergies?** Yes No
If yes, please list _____