

HIP OR LEG PAIN

Where is the pain located? (Check all that apply)

- Hip (right/left) Thigh (right/left) Knee (right/left) Lower Leg (right/left)
- Ankle (right/left) Foot (right/left) Toes (right/left)

What is the quality (description) of the pain?

- Aching Burning Gnawing Numbing Electric Shock
- Sensation of Heaviness Other, describe: _____

On a severity scale of 1-10 (1 being little pain at all and 10 being intolerable) my pain is a _____

Measure the severity of the pain regarding how it affects your daily activities:

- Mild – I am aware of it when present but it doesn't interfere with daily activities
- Moderate – when present it interferes only with some daily activities
- Severe – when present it interferes with most, but not all, daily activities
- Very severe – when present I am unable to carry out any daily activities
- Other description of severity _____

Are you experiencing the pain now? Yes No

How long have you had the pain? _____

Setting in which problem first occurred:

- Around the house, briefly describe: _____
- Injury on the job
 - Date of accident: _____
 - Description of accident or injury: _____
 - Was it reported to workman's comp? Yes No
 - Are you off work due to the accident or injury? Yes No
- Motor vehicle accident
 - Circumstances of accident: _____
 - Mechanism of injury: _____
- Overuse, repetitive motion injury, briefly describe: _____
- Sports injury, briefly describe: _____
- Other, briefly describe: _____
- Unknown

List any factors that aggravate the pain: _____

List any non-medical factors that relieve the pain: _____

Please note any of these factors that go along with the pain:

- | | | |
|--|---|--|
| <input type="checkbox"/> Bleeding | <input type="checkbox"/> Fever | <input type="checkbox"/> Numbness |
| <input type="checkbox"/> Bone misalignment | <input type="checkbox"/> Joint problems | <input type="checkbox"/> Pain |
| <input type="checkbox"/> Cramping | <input type="checkbox"/> Language difficulty | <input type="checkbox"/> Paralysis |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Mental status change | <input type="checkbox"/> Sleep disturbance |
| <input type="checkbox"/> Drainage | <input type="checkbox"/> Muscle tightness | <input type="checkbox"/> Swelling |
| <input type="checkbox"/> Drop objects | <input type="checkbox"/> Muscle weakness | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Fatigue | <input type="checkbox"/> Nausea | <input type="checkbox"/> None |

List any previous tests you have had: _____

List any previous treatments you have had: (home remedies, physical or occupational therapies, acupuncture therapies, massage therapy, chiropractic therapy, etc) and their effectiveness:

List any medications you have tried and their effectiveness: _____
