Montfort

713, chemin Montréal,
Ottawa (Ontario) K1K 0T2

Étiquette patient / *Patient ID*

SOINS AMBULATOIRES / *AMBULATORY CARE*
CLINIQUE D'ÉVALUATION EN ARTHROPLASTIE / *TOTAL JOINT ASSESSMENT CLINIC*

Hip History

Chief complaint: **Hip**: □ Right □ Left
Other complaint: **Knee**: □ Right □ Left
Back pain □ Yes □ No **Groin pain** □ Yes □ No
When and how did your hip pain start? (Give date): _____
_____

What treatments have you tried for your hip?

Physiotherapy	□ Yes □ No	Topical cream	□ Yes □ No
Exercise	□ Yes □ No	Heat/Ice	□ Yes □ No
Cortisone injection	□ Yes □ No	Weight loss	□ Yes □ No
Other injections	□ Yes □ No	Other health Professional	□ Yes □ No
_____		_____	

Does the pain in your hip wake you up at night? Please Circle
YES NO SOMETIMES

Walking distance? □ Unlimited □ Maximum (time/distance) _____

Do you use any of the following to help you walk? Please Circle
None Cane Walker Crutches Poles

Functional limitations: _____

Do you have difficulty putting on socks and shoes? YES NO

Pain: On average, how bad has your pain been over the past 2 days? Please circle.

	No Pain										*Severe pain*
Morning:	0	1	2	3	4	5	6	7	8	9	10
Afternoon:	0	1	2	3	4	5	6	7	8	9	10
Evening:	0	1	2	3	4	5	6	7	8	9	10
With activity:	0	1	2	3	4	5	6	7	8	9	10

Do not write below – FOR ASSESSOR USE ONLY

Stairs	□ Unlimited □ Non-reciprocal □ Unable	Leads up with: □ Right □ Left	**Paresthesia/ Numbness**	Right □ Yes □ No	Left □ Yes □ No
Pain	Location/Quality: Numeric rating scale:		Aggravated by: Relieved by:		

Signature/Title: _____ Date: _____ (*dd-mm-yyyy*)

Name of therapist (print letters):_____