HOOS HIP SURVEY

NAME: ____ DATE: __________________

This survey asks for your view about your hip. This information will help us keep track of how you feel about your hip and how well you are able to perform your usual activities. Answer every question by circling the appropriate number, only one for each question. If you are unsure about how to answer a question, please give the best answer you can.

	SYMPTOMS: These questions should be answered about your hip symptoms and difficulties during the last week.	NEVER	RARELY	SOMETIMES	OFTEN	ALWAYS
S1	Do you feel grinding, clear clicking or any other type of noise from your hip?	0	1	2	3	4
S2	Do you have difficulties spreading your legs wide apart?	0	1	2	3	4
S3	Do you have difficulties striding out when walking?	0	1	2	3	4
	Stiffness: These questions concern the amount of joint stiffness you have experienced during the last week. (Stiff is a sensation of restriction or slowness in the ease of movement.)	NONE	MILD	MODERATE	SEVERE	EXTREME
S4	How severe is your hip joint stiffness after first waking up in the morning?	0	1	2	3	4
S5	How sever is your hip joint stiffness after sitting, lying or resting later in the day?	0	1	2	3	4
	To be completed by the therapist: 100 – (Total Score x 100/28) SYMPTOMS SCORE:					
	PAIN: What amount of hip pain have you experienced during the following activities?					
P1	How often is your hip painful?	NEVER	MONTHLY	WEEKLY	DAILY	ALWAYS
P2	Straightening your hip fully	0	1	2	3	4
P3	Bending your hip fully	0	1	2	3	4
P4	Walking on flat surface	0	1	2	3	4
P5	Going up or down stairs	0	1	2	3	4
P6	At night while in bed	0	1	2	3	4
P7	Sitting or lying	0	1	2	3	4
P8	Standing upright	0	1	2	3	4
P9	Walking on a hard surface (asphalt, concrete, etc.)	0	1	2	3	4
P10	Walking on an uneven surface	0	1	2	3	4
	To be completed by the therapist: 100 – (Total Score x 100/36) PAIN SCORE:					

HOOS HIP SURVEY (continued)

	FUNCTION/DAILY LIVING: These questions concern your ability to move around and to look after yourself. Please indicate the degree of difficulty you have experienced in the last week.	NONE	MILD	MODERATE	SEVERE	EXTREME
A1	Descending stairs	0	1	2	3	4
A2	Ascending stairs	0	1	2	3	4
A3	Rising from sitting	0	1	2	3	4
A4	Standing	0	1	2	3	4
A5	Bending to the floor/pick up object	0	1	2	3	4
A6	Walking on a flat surface	0	1	2	3	4
A7	Getting in/out of car	0	1	2	3	4
A8	Going shopping	0	1	2	3	4
A9	Putting on socks/stockings	0	1	2	3	4
A10	Rising from bed	0	1	2	3	4
A11	Taking off socks/stockings	0	1	2	3	4
A12	Lying in bed (turning over, maintaining hip position)	0	1	2	3	4
A13	Getting in/out of bath	0	1	2	3	4
A14	Sitting	0	1	2	3	4
A15	Getting on/off toilet	0	1	2	3	4
A16	Heavy domestic duties (moving heavy boxes, scrubbing floors, etc.)	0	1	2	3	4
A17	Light domestic duties (cooking, dusting, etc.)	0	1	2	3	4
	To be completed by the therapist: 100 – (Total Score x 100/68) ADL SCORE:					
	FUNCTION, SPORTS & RECREATIONAL ACTIVITIES: The following questions concern your physical function when being active on a higher level. The questions should be answered thinking of what degree of difficulty you have experienced during the last week due to your hip.	NONE	MILD	MODERATE	SEVERE	EXTREME
SP1	Squatting	0	1	2	3	4
SP2	Running	0	1	2	3	4
SP3	Twisting/pivoting on loaded leg	0	1	2	3	4
SP4	Walking on uneven surface	0	1	2	3	4
	To be completed by the therapist: 100 – (Total Score x 100/20) SPORTS SCORE:					
	QUALITY OF LIFE: Please circle the appropriate responses.					
Q1	How often are you aware of your hip problem?	NEVER	MONTHLY	WEEKLY	DAILY	ALWAYS
Q2	Have you modified your lifestyle to avoid potentially damaging activities to your hip?	NOT AT ALL	MILDLY	MODERATELY	SEVERELY	EXTREMELY
Q3	How much are you troubled with lack of confidence in your hip?	NOT AT ALL	MILDLY	MODERATELY	SEVERELY	EXTREMELY
Q4	In general, how much difficulty do you have with your hip?	NONE	MILD	MODERATE	SEVERE	EXTREME
	To be completed by the therapist: 100 – (Total Score x 100/16) QOL SCORE:					

THE LOWER EXTREMITY FUNCTIONAL SCALE

This questionnaire has been designed to give the doctor/physical therapist information as to how your lower limb has affected your ability to manage in daily life. Please answer every question by circling the number below the appropriate response. Please only mark ONE response per question.

	Today, do you or would you have any difficulty at all with:	EXTREME DIFFICULTY OR UNABLE TO PERFORM	QUITE A BIT OF DIFFICULTY	MODERATE DIFFICULTY	A LITTLE BIT OF DIFFICULTY	NO DIFFICULTY
1	Any of your usual work, housework, or school activities.	0	1	2	3	4
2	Your usual hobbies, recreational or sporting activities.	0	1	2	3	4
3	Getting into or out of the bath.	0	1	2	3	4
4	Walking between rooms.	0	1	2	3	4
5	Putting on your shoes or socks.	0	1	2	3	4
6	Squatting.	0	1	2	3	4
7	Lifting an object, like a bag of groceries from the floor.	0	1	2	3	4
8	Performing light activities around your home.	0	1	2	3	4
9	Performing heavy activities around your home.	0	1	2	3	4
10	Getting into or out of the car.	0	1	2	3	4
11	Walking 2 blocks.	0	1	2	3	4
12	Walking 1 mile.	0	1	2	3	4
13	Going up or down 10 stairs (about 1 flight of stairs).	0	1	2	3	4
14	Standing for 1 hour.	0	1	2	3	4
15	Sitting for 1 hour.	0	1	2	3	4
16	Running on even ground.	0	1	2	3	4
17	Running on uneven ground.	0	1	2	3	4
18	Making sharp turns while running fast.	0	1	2	3	4
19	Hopping.	0	1	2	3	4
20	Rolling over in bed.	0	1	2	3	4

To be completed by physical therapist/provider only SCORE: __________/80