NHS Redditch and Bromsgrove Clinical Commissioning Group | NHS South Worcestershire Clinical Commissioning Group | NHS Wyre Forest Clinical Commissioning Group

PROBLEMS WITH YOUR HIP ?

Your Details

GP Practice:		**GP:**	
Your Name:		**Your Date of Birth:**	
Your Address:		**Your Contact Telephone Number:**	
Your NHS Number:		**Date You Completed This Questionnaire:**	

During the Past 4 weeks… Tick one box for each question

1	How would you describe the pain you usually have from your hip?				
	None ☐ **(4)**	Very Mild ☐ **(3)**	Mild ☐ **(2)**	Moderate ☐ **(1)**	Severe ☐ **(0)**
2	Have you had any trouble with washing and drying yourself (all over) because of your hip?				
	No Trouble At All ☐ **(4)**	Very Little Trouble ☐ **(3)**	Moderate Trouble ☐ **(2)**	Extreme Difficulty ☐ **(1)**	Impossible To Do ☐ **(0)**
3	Have you had any trouble getting in and out of a car or using public transport because of your hip? *(whichever you would normally use)*				
	No Trouble At All ☐ **(4)**	Very Little Trouble ☐ **(3)**	Moderate Trouble ☐ **(2)**	Extreme Difficulty ☐ **(1)**	Impossible To Do ☐ **(0)**
4	For how long have you been able to walk before pain from your hip becomes **severe**? *(with or without a walking aid like a stick/frame)*				
	No Pain/ More Than 30 Minutes ☐ **(4)**	16 to 30 Minutes ☐ **(3)**	5 to 15 Minutes ☐ **(2)**	Around the House Only ☐ **(1)**	Not At All Pain Severe When Walking ☐ **(0)**
5	After a meal (sat at a table), how painful has it been for you to stand up from a chair because of your hip?				
	Not At All Painful ☐ **(4)**	Slightly Painful ☐ **(3)**	Moderately Painful ☐ **(2)**	Very Painful ☐ **(1)**	Unbearable ☐ **(0)**

Please Turn Over – More Questions Overleaf…

NHS Redditch and Bromsgrove Clinical Commissioning Group

NHS South Worcestershire Clinical Commissioning Group

NHS Wyre Forest Clinical Commissioning Group

6	Have you been limping when walking, because of your hip?				
	Rarely/ Never ☐ **(4)**	Sometimes Or Just At First ☐ **(3)**	Often, Not Just At First ☐ **(2)**	Most Of The Time ☐ **(1)**	All Of The Time ☐ **(0)**
7	Have you had any sudden, severe pain (shooting, stabbing or spasms) from your affected hip?				
	No Days ☐ **(4)**	Only 1 or 2 Days ☐ **(3)**	Some Days ☐ **(2)**	Most Days ☐ **(1)**	Every Day ☐ **(0)**
8	Have you been troubled by pain from your hip in bed at night?				
	No Nights ☐ **(4)**	Only 1 or 2 Nights ☐ **(3)**	Some Nights ☐ **(2)**	Most Nights ☐ **(1)**	Every Night ☐ **(0)**
9	How much has pain from your hip interfered with your usual work (*including housework)*?				
	Not At All ☐ **(4)**	A Little Bit ☐ **(3)**	Moderately ☐ **(2)**	Greatly ☐ **(1)**	Totally ☐ **(0)**
10	Have you been able to put on a pair of socks, stockings or tights?				
	Yes Easily ☐ **(4)**	With Little Difficulty ☐ **(3)**	With Moderate Difficulty ☐ **(2)**	With Extreme Difficulty ☐ **(1)**	No Impossible ☐ **(0)**
11	**Could** you do the household shopping on your own?				
	Yes Easily ☐ **(4)**	With Little Difficulty ☐ **(3)**	With Moderate Difficulty ☐ **(2)**	With Extreme Difficulty ☐ **(1)**	No Impossible ☐ **(0)**
12	**Could** you climb up one flight of stairs?				
	Yes Easily ☐ **(4)**	With Little Difficulty ☐ **(3)**	With Moderate Difficulty ☐ **(2)**	With Extreme Difficulty ☐ **(1)**	No Impossible ☐ **(0)**

Thank you for completing this questionnaire, please give this sheet to the Physiotherapist or Reception/your GP at your practice

For Practice Use Only	
Calculated Oxford Hip Score For Patient Name:	