

## HOOS HIP SURVEY

Today's Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Date of Birth: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Name: \_\_\_\_\_

### Please rate your pain level with activity:

0      1      2      3      4      5      6      7      8      9      10  
 No Pain Very Severe Pain

**INSTRUCTIONS:** 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 do your usual activities. Answer every question by ticking the appropriate box, only one box for each question. If you are uncertain about how to answer a question, please give the best answer you can.

### Symptoms

These questions should be answered thinking of your hip symptoms and difficulties during the **last week**.

S1. Do you feel grinding, hear clicking or any other type of noise from your hip?

Never       Rarely       Sometimes       Often       Always

S2. Difficulties spreading legs wide apart

None       Mild       Moderate       Severe       Extreme

S3. Difficulties to stride out when walking

None       Mild       Moderate       Severe       Extreme

### Stiffness

The following questions concern the amount of joint stiffness you have experienced during the **last week** in your hip. Stiffness is a sensation of restriction or slowness in the ease with which you move your hip joint.

S4. How severe is your hip joint stiffness after first wakening in the morning?

None       Mild       Moderate       Severe       Extreme

S5. How severe is your hip stiffness after sitting, lying or resting later in the day?

None       Mild       Moderate       Severe       Extreme

## Pain

P1. How often is your hip painful?

- Never       Monthly       Weekly       Daily       Always

What amount of hip pain have you experienced the last week during the following activities?

P2. Straightening your hip fully

- None       Mild       Moderate       Severe       Extreme

What amount of hip pain have you experienced the last week during the following activities?

P3. Bending your hip fully

- None       Mild       Moderate       Severe       Extreme

P4. Walking on a flat surface

- None       Mild       Moderate       Severe       Extreme

P5. Going up or down stairs

- None       Mild       Moderate       Severe       Extreme

P6. At night while in bed

- None       Mild       Moderate       Severe       Extreme

P7. Sitting or lying

- None       Mild       Moderate       Severe       Extreme

P8. Standing upright

- None       Mild       Moderate       Severe       Extreme

P9. Walking on a hard surface (asphalt, concrete, etc.)

- None       Mild       Moderate       Severe       Extreme

P10. Walking on an uneven surface

- None       Mild       Moderate       Severe       Extreme

## Function, daily living

The following questions concern your physical function. By this we mean your ability to move around and to look after yourself. For each of the following activities please indicate the degree of difficulty you have experienced in the **last week** due to your hip.

A1. Descending stairs

None  Mild  Moderate  Severe  Extreme

A2. Ascending stairs

None  Mild  Moderate  Severe  Extreme

A3. Rising from sitting

None  Mild  Moderate  Severe  Extreme

A4. Standing

None  Mild  Moderate  Severe  Extreme

For each of the following activities please indicate the degree of difficulty you have experienced in the **last week** due to your hip.

A5. Bending to floor/pick up an object

None  Mild  Moderate  Severe  Extreme

A6. Walking on flat surface

None  Mild  Moderate  Severe  Extreme

A7. Getting in/out of car

None  Mild  Moderate  Severe  Extreme

A8. Going shopping

None  Mild  Moderate  Severe  Extreme

A9. Putting on socks/stockings

None  Mild  Moderate  Severe  Extreme

A10. Rising from bed

None  Mild  Moderate  Severe  Extreme

A11. Taking off socks/stockings

None  Mild  Moderate  Severe  Extreme

A12. Lying in bed (turning over, maintaining hip position)

None  Mild  Moderate  Severe  Extreme

A13. Getting in/out of bath

None  Mild  Moderate  Severe  Extreme

A14. Sitting

None  Mild  Moderate  Severe  Extreme

A15. Getting on/off toilet

None  Mild  Moderate  Severe  Extreme

A16. Heavy domestic duties (moving heavy boxes, scrubbing floors, etc)

None  Mild  Moderate  Severe  Extreme

A17. Light domestic duties (cooking, dusting, etc)

None  Mild  Moderate  Severe  Extreme

### Function, sports and 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.

SP1. Squatting

None  Mild  Moderate  Severe  Extreme

SP2. Running

None  Mild  Moderate  Severe  Extreme

SP3. Twisting/pivoting on loaded leg

- None       Mild       Moderate       Severe       Extreme

SP4. Walking on uneven surface

- None       Mild       Moderate       Severe       Extreme

### Quality of Life

Q1. How often are you aware of your hip problem?

- Never       Monthly       Weekly       Daily       Constantly

Q2. Have you modified your life style to avoid activities potentially damaging to your hip?

- Not at all       Mildly       Moderately       Severely       Totally

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

Thank you very much for completing all the questions in this questionnaire.