FOTO Patient Intake Survey Hip

Name: Date:

Please Read Carefully: Answer each question based on the p**roblem for which you are receiving treatment**. Mark which column best describes how you are able to do each activity. Please answer each question even if you do not do or have not done this activity. Make your best guess as to which response is most accurate.

Because of your affected hip do you or would you have any difficulty...	Extreme difficulty/ Unable to do	Quite a bit of difficulty	Moderate Difficulty	A little bit of difficulty	No Difficutly
1. Any of your usual work, housework or school activities					
2. Walking between rooms					
3. Squatting					
4. Performing light activities around your home					
5. Performing heavy activities around your home					
6. Walking two blocks					
7. Getting up or down 10 stairs (about 1 flight of stairs)					
8. Standing for 1 hour					
9. Running on even ground					
10. Hopping					