Place label here

Hip Disability Questionnaire

Date:_____________

Please read carefully: The purpose of the scale is to identify difficulties that you may be experiencing because of your hip pain. Please check off "YES", "SOMETIMES", or "NO"

Rate the severity of each of the following problems:	1 Not	2 Minimally	3 Somewhat	4 Moderately	5 Very	6 Extremely	Not Applicable
Average daytime hip pain							
Nighttime hip pain							
Hip stiffness							
Limp							
Rate the degree to which each of the following problems bother you	1 Not	2 Minimally	3 Somewhat	4 Moderately	5 Very	6 Extremely	Not Applicable
Having to take pills							
Having to use walking aids							
Difference in leg lengths							
Fear of falling because of hip							
Loss of independence							
Rate the degree of difficulty you have doing each of the following activities	1 Not	2 Minimally	3 Somewhat	4 Moderately	5 Very	6 Extremely	Not Applicable
Walking							
Going up and down stairs							
Putting on shoes or socks							
Sitting							
Using public transportation							
Driving							
Job/housework							
Tub baths							
Bending to pick things up off floor							
Standing for 5 min.							

Comments: ____

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