

**HOOS, JR. HIP SURVEY**

**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 unsure about how to answer a question, please give the best answer you can.

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

|  |  |  |  |
| --- | --- | --- | --- |
| 1. Going up or down stairs |  |  |  |
| None Mild | Moderate | Severe | Extreme |
|    2. 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.

|  |  |
| --- | --- |
| 3. Rising from sitting |  |
| None Mild Moderate Severe | Extreme |
|      4. Bending to floor/pick up an object |  |
| None Mild Moderate Severe | Extreme |
|      5. Lying in bed (turning over, maintaining hip position) |  |
| None Mild Moderate Severe | Extreme |
|      6. Sitting |  |
| None Mild Moderate Severe | Extreme |
|     |  |

NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_