

Name _____ Date _____

MODIFIED HARRIS HIP SCORE

Please answer the following questions as they pertain to your hip:

Pain:

- None/Able to ignore it
- Slight, occasional, no compromise in activity
- Mild, no effect on ordinary activity, pain after usual activity, use aspirin/ibuprofen/Tylenol
- Moderate, tolerable, makes concessions, occasional narcotic
- Marked, serious limitations
- Totally disabled

Function: Gait

Limp

- None
- Slight
- Moderate
- Severe
- Unable to walk

Support

- None
- Cane for long walks
- Cane all the time
- Crutch
- 2 canes
- 2 crutches
- Unable to walk

Distance Walked

- Unlimited
- 6 blocks
- 2-3 blocks
- Indoors only
- Bed and chair

Functional Activities

Stairs

- Can go up/down normally
- Can go up/down normally with banister
- Any method
- Unable

Socks/Shoes

- With ease
- With difficulty
- Unable

Sitting

- Any chair, 1 hour
- High chair, ½ hour
- Unable to sit, ½ hour, any chair

Public Transportation

- Able to enter public transportation
- Unable to use public transportation
(such as bus, or airport transportation)

For Internal Use:

Score _____
Initials _____

APPENDIX 1. NONARTHRITIC HIP SCORE

INSTRUCTIONS: The following 5 questions concern the amount of pain you are currently experiencing in the hip that you are having evaluated today. For each situation, please circle the response that most accurately reflects the amount of pain experienced in the past 48 hours. Please circle one answer that best describes your situation.

QUESTION: How much pain do you have-

- | | |
|--|---|
| 1. Walking on a flat surface?
4 = none
3 = mild
2 = moderate
1 = severe
0 = extreme | 4. Sitting or lying?
4 = none
3 = mild
2 = moderate
1 = severe
0 = extreme |
| 2. Going up or down stairs?
4 = none
3 = mild
2 = moderate
1 = severe
0 = extreme | 5. Standing upright?
4 = none
3 = mild
2 = moderate
1 = severe
0 = extreme |
| 3. At night while in bed?
4 = none
3 = mild
2 = moderate
1 = severe
0 = extreme | |

INSTRUCTIONS: The following 4 questions concern the symptoms that you are currently experiencing in the hip that you are having evaluated today. For each situation, please circle the response that most accurately reflects the symptoms experienced in the past 48 hours. Please circle one answer that best describes your situation.

QUESTION: How much trouble do you have with-

- | | |
|--|---|
| 1. Catching or locking of your hip?
4 = none
3 = mild
2 = moderate
1 = severe
0 = extreme | 3. Stiffness in your hip?
4 = none
3 = mild
2 = moderate
1 = severe
0 = extreme |
| 2. Your hip giving out on you?
4 = none
3 = mild
2 = moderate
1 = severe
0 = extreme | 4. Decreased motion in your hip?
4 = none
3 = mild
2 = moderate
1 = severe
0 = extreme |

INSTRUCTIONS: The following 5 questions concern your physical function. For each of the following activities, please circle the response that most accurately reflects the difficulty that you have experienced in the past 48 hours because of your hip pain. Please circle one answer that best describes your situation.

QUESTION: What degree of difficulty do you have with-

- | | |
|--|---|
| <p>1. Descending stairs?
4 = none
3 = mild
2 = moderate
1 = severe
0 = extreme</p> | <p>4. Putting on socks/stockings?
4 = none
3 = mild
2 = moderate
1 = severe
0 = extreme</p> |
| <p>2. Ascending stairs?
4 = none
3 = mild
2 = moderate
1 = severe
0 = extreme</p> | <p>5. Rising from bed?
4 = none
3 = mild
2 = moderate
1 = severe
0 = extreme</p> |
| <p>3. Rising from sitting?
4 = none
3 = mild
2 = moderate
1 = severe
0 = extreme</p> | |

INSTRUCTIONS: The following 6 questions concern your ability to participate in certain types of activities. For each of the following activities, please circle the response that most accurately reflects the difficulty that you have experienced in the past month because of your hip pain. If you do not participate in a certain type of activity, please estimate how much trouble your hip would cause you if you had to perform that type of activity. Please circle one answer that best describes your situation.

QUESTION: How much trouble does your hip cause you when you participate in-

- | | |
|--|---|
| <p>1. High demand sports involving sprinting or cutting (for example, football, basketball, tennis, and exercise aerobics)
4 = none
3 = mild
2 = moderate
1 = severe
0 = extreme</p> | <p>3. Jogging for exercise?
4 = none
3 = mild
2 = moderate
1 = severe
0 = extreme</p> |
| <p>2. Low demand sports (for example, golfing and bowling)
4 = none
3 = mild
2 = moderate
1 = severe
0 = extreme</p> | <p>4. Walking for exercise?
4 = none
3 = mild
2 = moderate
1 = severe
0 = extreme</p> |

5. Heavy household duties (for example, lifting firewood and moving furniture)?
4 = none
3 = mild
2 = moderate
1 = severe
0 = extreme
6. Light household duties (for example, cooking, dusting, vacuuming, and doing laundry)?
4 = none
3 = mild
2 = moderate
1 = severe
0 = extreme

INSTRUCTIONS: Please add the numbers associated with each of your 20 answers to arrive at the raw score, Multiply the raw score by 1.25 to obtain your hip score.

References

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**Hip Outcome Score (HOS)
Activity of Daily Living Scale**

Please answer **every question** with one response that most closely describes to your condition within the past week.

If the activity in question is limited by something other than your hip mark not applicable (N/A).

	No difficulty at all	Slight difficulty	Moderate difficulty	Extreme difficulty	Unable to do	N/A
Standing for 15 minutes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Getting into and out of an average car	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Putting on socks and shoes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Walking up steep hills	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Walking down steep hills	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Going up 1 flight of stairs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Going down 1 flight of stairs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stepping up and down curbs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Deep squatting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Getting into and out of a bath tub	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sitting for 15 minutes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Walking initially	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Walking approximately 10 minutes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Walking 15 minutes or greater	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Because of your hip how much difficulty do you have with:

	No difficulty at all	Slight difficulty	Moderate difficulty	Extreme difficulty	Unable to do	N/A
Twisting/pivoting on involved leg	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Rolling over in bed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Light to moderate work (standing, walking)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heavy work (push/pulling, climbing, carrying)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Recreational activities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

How would you rate your current level of function during your usual activities of daily living from 0 to 100 with 100 being your level of function prior to your hip problem and 0 being the inability to perform any of your usual daily activities?

.0 %

**Hip Outcome Score (HOS)
Sports Scale**

Because of your hip how much difficulty do you have with:

	No difficulty at all	Slight difficulty	Moderate difficulty	Extreme difficulty	Unable to do	N/A
Running one mile	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Jumping	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Swinging objects like a golf club	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Landing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Starting and stopping quickly	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cutting/lateral movements	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Low impact activities like fast walking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ability to perform activity with your normal technique	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ability to participate in your desired sport as long as you would like	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

How would you rate your current level of function during your sports related activities from 0 to 100 with 100 being your level of function prior to your hip problem and 0 being the inability to perform any of your usual daily activities?

.0 %

How would you rate your current level of function?

Normal Nearly normal Abnormal Severely abnormal

--	--	--	--	--	--

NAME: _____

DATE:

--	--

 /

--	--

 /

--	--	--	--

INJURED HIP: Right Left Both

VHS

Please complete the following based on your hip

	<i>No Pain</i>											<i>Severe Pain</i>
1. Today:	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5	<input type="radio"/> 6	<input type="radio"/> 7	<input type="radio"/> 8	<input type="radio"/> 9	<input type="radio"/> 10	
2. Following activity	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5	<input type="radio"/> 6	<input type="radio"/> 7	<input type="radio"/> 8	<input type="radio"/> 9	<input type="radio"/> 10	

3. Please select the one response that best reflects your pain:

- | | |
|--|--|
| <input type="radio"/> 1. None or you ignore it
<input type="radio"/> 2. Slight, occasional, no compromise in activity
<input type="radio"/> 3. Mild, no effect on average activities | <input type="radio"/> 4. Moderate pain, tolerable but concessions to pain are made.
<input type="radio"/> 5. Marked pain, serious limitation of activity
<input type="radio"/> 6. Totally disabled, crippled, pain in bed, bedridden |
|--|--|

4. After 6 to 9 blocks (about 1 mile), please describe how you would walk:(please select only one response)

1. No limp 2. Slight limp 3. Moderate limp 4. Severe limp

How much trouble do you have with...

	NONE	MILD	MODERATE	SEVERE	EXTREME
5. Stiffness in your hip?	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5
6. Decrease motion of your hip?	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5

Because of your hip, how much difficulty do you have with:

	<u>No Difficulty at all</u>	<u>Slight Difficulty</u>	<u>Moderate Difficulty</u>	<u>Extreme Difficulty</u>	<u>Unable to do</u>	N/A
7. Twisting/pivoting on involved leg	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5	<input type="radio"/> 6
8. Deep squatting	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5	<input type="radio"/> 6
9. Heavy work (push/pulling, climbing, carrying)	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5	<input type="radio"/> 6
10. Recreational activities	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5	<input type="radio"/> 6

How would you rate your current level of function? Normal Nearly Normal Abnormal Severely Abnormal



Name: _____

Date: _____

MAHORN Hip Outcome Tool (MHOT¹⁴)

Quality of Life Questionnaire for Young, Active Patients with Hip Problems

Instructions:

- These questions ask about the problems you may be experiencing in your hip, how these problems affect your life, and the emotions you may feel because of these problems.
- Please answer each question with respect to the current status, function, circumstances and beliefs related to your hip.
- Consider the last **month**.
- The questions are formatted so that you can indicate the severity of the problem by marking the line below the question.

Please note:

Please mark the line with a slash at the point which most closely represents your situation.

- If you put a mark on the far **left**, it means that you **feel you are significantly impaired**.
For example:

Significantly impaired / _____ **No problems at all**

- If you put a mark on the far **right**, it means that you **do not think that you have any problems** with your hip.
For example:

Significantly impaired _____ / **No problems at all**

If the mark is placed in the middle of the line, this indicates that you are moderately disabled, or in other words, between the extremes of 'significantly impaired' and 'no problems at all'. It is important to put your mark at either end of the line if the extreme descriptions accurately reflect your situation.

If the question asks about something that you do not experience, please mark the option:

I do not do this action in my activities, where this is appropriate.

I: SYMPTOMS AND FUNCTIONAL LIMITATIONS

The following questions ask about symptoms that you may experience in your **hip** and about the function of your **hip** with respect to daily activities. Please think about how you have felt most of the time over the past **month** and answer accordingly.

1. How difficult is it for you to walk long distances?

Extremely difficult _____ Not difficult at all

2. How difficult is it for you to get up and down off the floor/ground?

Extremely difficult _____ Not difficult at all

3. How difficult is it for you to lie on your affected hip side?

Extremely difficult _____ Not difficult at all

4. How much trouble do you have with grinding, catching or clicking in your hip?

Severe trouble _____ No trouble at all

5. Overall, how much pain do you have in your hip/groin?

Extreme pain _____ No pain at all

II: SPORTS AND RECREATIONAL ACTIVITIES

The following questions ask about your **hip** when you participate in sports and recreational activities. Please think about how you have felt most of the time over the past **month** and answer accordingly.

6. How concerned are you about your ability to maintain your desired fitness level?

Extremely concerned _____ Not concerned at all

7. How much pain do you experience in your hip after activity?

Extreme pain _____ No pain at all

8. How concerned are you about cutting/changing directions during your sport or recreational activities?

I do not do this action in my activities

Extremely concerned _____ Not concerned at all

III: JOB RELATED CONCERNS

The following questions relate to your **hip** with respect to your work or occupational activities. Please think about how you have felt most of the time over the past **month** and answer accordingly.

I am retired (please skip section)

I do not work for reasons other than my hip condition (please skip section)

9. How much trouble do you have pushing, pulling, lifting or carrying heavy objects at work?

I do not do these actions in my work

Severe trouble _____ No trouble at all

10. How much difficulty do you have at work because of reduced hip mobility?

Extreme difficulty _____ **No difficulty at all**

IV: SOCIAL, EMOTIONAL AND LIFESTYLE CONCERNS

The following questions ask about social, emotional and lifestyle concerns that you may feel with respect to your **hip** problem. Please think about how you have felt most of the time over the past **month** and answer accordingly.

11. How much trouble do you have with sexual activity because of your hip?

This is not relevant to me

Severe trouble _____ **No trouble at all**

12. How much of a distraction is your hip problem?

Extreme distraction _____ **No distraction at all**

13. How concerned are you about picking up or carrying children because of your hip?

I do not do this action in my activities

Extremely concerned _____ **Not concerned at all**

14. How much of the time are you aware of the disability in your hip?

Constantly aware _____ **Not aware at all**

***QUESTIONNAIRE COMPLETE!
THANK YOU!***

MAHORN Hip Outcome Tool MHOT ^{14/33}

“Quality of Life Questionnaire for Young, Active Patients with Hip Problems”

Scoring the questionnaire

This is a self administered questionnaire. Every question should be answered by the patients. There are exceptions as follows: questions i.e. #21, #28, #32, and the Job related concerns domain, allow patients to check a box that these items are not part of their activity or relevant. All other questions should be answered.

Each question has a response format which is a visual analogue scale that is meant to be exactly 100 mm in length. Therefore, each question can be answered from 0-100 points or 0-100%. **Quality of life is a good thing therefore a higher score is better.** A score of 100 would be considered optimal quality of life with respect to a person with a hip problem.

It is very simple to score the questionnaire. Measure each visual analogue line from left to right with a 100 mm ruler. Read the score from 0-100 and right down the number (eg. 22 mm equals a score of 22 etc.). **The total score is the sum of all of the answered questions divided by the number of questions answered.** For example: If a patient only answered 32 out of the 33 questions the numerator would be the sum of the 32 questions and the denominator would be 32.

It is also possible to obtain separate scores on each of the four domains of the questionnaire. The four domains are:

1. Symptoms and functional limitations
2. Sports and recreational activities
3. Job related concerns
4. Social, Emotional and Lifestyle concerns

The same formula applies to each domain by dividing the total score by the number of questions answered within the domain in question. Experience with other similar questionnaires demonstrates that some patients will be more or less impaired in one domain or the other. For example; a patient who has an office job may not have much impairment in their quality of life with respect to this domain. A professional athlete would likely be the opposite.

The questionnaire should be used at baseline assessment of the patient and at follow up appointments. It is recommended that a minimum of one month has passed between administrations of the Hip-QOL, since patients are asked to reflect their answers to the questions over the past month. It is more likely that changes in quality of life will be measureable at longer time periods such as 2-3 months.

Name: _____

Date: _____

MAHORN Hip Outcome Tool MHOT ³³

Quality of Life Questionnaire for Young, Active Patients with Hip Problems

Instructions:

- These questions ask about the problems you may be experiencing in your hip, how these problems affect your life, and the emotions you may feel because of these problems.
- Please answer each question with respect to the current status, function, circumstances and beliefs related to your hip.
- Consider the last **month**.
- The questions are formatted so that you can indicate the severity of the problem by marking the line below the question.

Please note:

Please mark the line with a slash at the point which most closely represents your situation.

- If you put a mark on the far **left**, it means that you **feel you are significantly impaired**.
For example:

Significantly impaired / _____ **No problems at all**

- If you put a mark on the far **right**, it means that you **do not think that you have any problems** with your hip.
For example:

Significantly impaired _____ / **No problems at all**

If the mark is placed in the middle of the line, this indicates that you are moderately disabled, or in other words, between the extremes of 'significantly impaired' and 'no problems at all'. It is important to put your mark at either end of the line if the extreme descriptions accurately reflect your situation.

If the question asks about something that you do not experience, please mark the option:

I do not do this action in my activities, where this is appropriate.

I: SYMPTOMS AND FUNCTIONAL LIMITATIONS

The following questions ask about symptoms that you may experience in your **hip** and about the function of your **hip** with respect to daily activities. Please think about how you have felt most of the time over the past **month** and answer accordingly.

1. How often does your hip/groin ache?

Constantly _____ Never

2. How stiff is your hip as a result of sitting/resting during the day?

Extremely stiff _____ Not stiff at all

3. How difficult is it for you to walk long distances?

Extremely difficult _____ Not difficult at all

4. How much pain do you have in your hip while sitting?

Extreme pain _____ No pain at all

5. How much trouble do you have standing on your feet for long periods of time?

Severe trouble _____ No trouble at all

6. How difficult is it for you to get up and down off the floor/ground?

Extremely difficult _____ Not difficult at all

7. How difficult is it for you to walk on uneven surfaces?

Extremely difficult _____ Not difficult at all

8. How difficult is it for you to lie on your affected hip side?

Extremely difficult _____ **Not difficult at all**

9. How much trouble do you have with stepping over obstacles?

Severe trouble _____ **No trouble at all**

10. How much trouble do you have with climbing up/down stairs?

Severe trouble _____ **No trouble at all**

11. How much trouble do you have with rising from a sitting position?

Severe trouble _____ **No trouble at all**

12. How much discomfort do you have with taking long strides?

Extreme discomfort _____ **No discomfort at all**

13. How much difficulty do you have with getting into and/or out of a car?

Extreme difficulty _____ **No difficulty at all**

14. How much trouble do you have with grinding, catching or clicking in your hip?

Severe trouble _____ **No trouble at all**

15. How much difficulty do you have with putting on/taking off socks, stockings or shoes?

Extreme difficulty _____ **No difficulty at all**

16. Overall, how much pain do you have in your hip/groin?

Extreme pain _____ No pain at all

II: SPORTS AND RECREATIONAL ACTIVITIES

The following questions ask about your **hip** when you participate in sports and recreational activities. Please think about how you have felt most of the time over the past **month** and answer accordingly.

17. How concerned are you about your ability to maintain your desired fitness level?

Extremely concerned _____ Not concerned at all

18. How much pain do you experience in your hip after activity?

Extreme pain _____ No pain at all

19. How concerned are you that the pain in your hip will increase if you participate in sports or recreational activities?

Extremely concerned _____ Not concerned at all

20. How much has your quality of life deteriorated because you cannot participate in sport/recreational activities?

Extremely deteriorated _____ No deterioration at all

21. How concerned are you about cutting/changing directions during your sport or recreational activities?

I do not do this action in my activities

Extremely concerned _____ Not concerned at all

22. How much has your performance level decreased in your sport or recreational activities?

Extremely decreased _____ Not decreased at all

III: JOB RELATED CONCERNS

The following questions relate to your **hip** with respect to your work or occupational activities. Please think about how you have felt most of the time over the past **month** and answer accordingly.

- I am retired (please skip section)
 I do not work for reasons other than my hip condition (please skip section)

23. How much trouble do you have pushing, pulling, lifting or carrying heavy objects at work?

I do not do these actions in my work

Severe trouble _____ No trouble at all

24. How much trouble do you have with crouching/squatting?

Severe trouble _____ No trouble at all

25. How concerned are you that your job will make your hip worse?

Extremely concerned _____ Not concerned at all

26. How much difficulty do you have at work because of reduced hip mobility?

Extreme difficulty _____ No difficulty at all

IV: SOCIAL, EMOTIONAL AND LIFESTYLE CONCERNS

The following questions ask about social, emotional and lifestyle concerns that you may feel with respect to your **hip** problem. Please think about how you have felt most of the time over the past **month** and answer accordingly.

27. How frustrated are you because of your hip problem?

Extremely _____ **Not frustrated**
frustrated at all

28. How much trouble do you have with sexual activity because of your hip?

This is not relevant to me

Severe _____ **No trouble**
trouble at all

29. How much of a distraction is your hip problem?

Extreme _____ **No distraction**
distraction at all

30. How difficult is it for you to release tension and stress because of your hip problem?

Extremely _____ **Not difficult**
difficult at all

31. How discouraged are you because of your hip problem?

Extremely _____ **Not discouraged**
discouraged at all

32. How concerned are you about picking up or carrying children because of your hip?

I do not do this action in my activities

Extremely _____ **Not concerned**
concerned at all

33. How much of the time are you aware of the disability in your hip?

Constantly _____ **Not aware at all**
aware

QUESTIONNAIRE COMPLETE!
THANK YOU!