TOEPPERWEIN PHYSICAL THERAPY & Spine Rehab

Hip Functional Assessment	*(Please mark only 1 box for each area)*	
	Affected Hip: ☐ Right	**☐ Left** **☐ Both**
I stay home most of the time because of my hip.	☐ True	☐ False
When I sit, I change positions frequently to get my hip comfortable.	☐ True	☐ False
I walk slower than normal because of my hip.	☐ True	☐ False
Because of my hip I am not doing any of the jobs that I usually do around the house.	☐ True	☐ False
Because of my hip I use handrails on stairs.	☐ True	☐ False
Because of my hip I lie down and rest more often.	☐ True	☐ False
Because of my hip I have difficulty driving.	☐ True	☐ False
I get dressed slower than normal because of my hip pain.	☐ True	☐ False
Because of my hip pain I try and get other people to do things for me.	☐ True	☐ False
I only stand for short periods of time because of my hip.	☐ True	☐ False
I find it difficult to get out of a chair because of my hip.	☐ True	☐ False
Because of my hip pain I cannot squat down.	☐ True	☐ False
My hip is painful almost all the time.	☐ True	☐ False
Running is difficult because of my hip.	☐ True	☐ False
My appetite is not good because of my hip.	☐ True	☐ False
I have trouble putting my shoes and socks on because of my hip.	☐ True	☐ False
I walk only short distances because of my hip.	☐ True	☐ False
I don't sleep as well because of my hip.	☐ True	☐ False
I have difficulty going up stairs because of my hip.	☐ True	☐ False
I have difficulty going down stairs because of my hip.	☐ True	☐ False
I sit down for most of the day because of my hip.	☐ True	☐ False
Because of my hip it takes me longer to get going in the morning.	☐ True	☐ False
Because of my hip pain I am more irritable and bad tempered with people than usual.	☐ True	☐ False
I need to take medication for my hip pain in order to complete daily activities.	☐ True	☐ False
I need to modify my fitness activities because of my hip.	☐ True	☐ False
_____ / 25 Functional Restrictions		

Name:_____ Date:_____

TOEPPERWEIN PHYSICAL THERAPY & Spine Rehab

(Please mark only 1 box for each area)

Lower Extremity Functional Scale	Extreme Difficulty	Quite a Bit Difficulty	Moderate Difficulty	A little Bit of Difficulty	No Difficulty
Any of your usual work, housework, or school activities.	☐0	☐ 1	☐ 2	☐3	☐ 4
Your usual hobbies, recreational or sporting activities.	☐0	☐ 1	☐ 2	☐3	☐ 4
Getting into or out of the bath.	☐0	☐ 1	☐ 2	☐3	☐ 4
Walking between rooms.	☐0	☐ 1	☐ 2	☐3	☐ 4
Putting on your shoes or socks.	☐0	☐ 1	☐ 2	☐3	☐ 4
Squatting.	☐0	☐ 1	☐ 2	☐3	☐ 4
Lifting an object, like a bag of groceries from the floor.	☐0	☐ 1	☐ 2	☐3	☐ 4
Performing light activities around your home.	☐0	☐ 1	☐ 2	☐3	☐ 4
Performing heavy activities around your home.	☐0	☐ 1	☐ 2	☐3	☐ 4
Getting into or out of a car.	☐0	☐ 1	☐ 2	☐3	☐ 4
Walking 2 blocks.	☐0	☐ 1	☐ 2	☐3	☐ 4
Walking a mile.	☐0	☐ 1	☐ 2	☐3	☐ 4
Going up or down 10 stairs (about 1 flight of stairs).	☐0	☐ 1	☐ 2	☐3	☐ 4
Standing for 1 hour.	☐0	☐ 1	☐ 2	☐3	☐ 4
Sitting for 1 hour.	☐0	☐ 1	☐ 2	☐3	☐ 4
Running on even ground.	☐0	☐ 1	☐ 2	☐3	☐ 4
Running on uneven ground.	☐0	☐ 1	☐ 2	☐3	☐ 4
Making sharp turns while running fast.	☐0	☐ 1	☐ 2	☐3	☐ 4
Hopping.	☐0	☐ 1	☐ 2	☐3	☐ 4
Rolling over in bed.	☐0	☐ 1	☐ 2	☐3	☐ 4
Column Totals:	_____	_____	_____	_____	_____
Minimum Level of Detectable Change (90% Confidence): 9 points	SCORE:_____/ 80				

Name:_____ Date:_____