

MEDICAL RECORD-SUPPLEMENTAL MEDICAL DATA
 For use of this form, see AR 40-66; the proponent agency is the Office of The Surgeon General

REPORT TITLE **Physical Therapy Re-Evaluation Form Hip Problem**

OTSG APPROVED (Date)

- Is Physical Therapy helping to increase your ability to function or decrease your pain/symptoms? Yes No
- Symptoms are? Increasing Unchanged Decreasing
- Symptoms are? Constant Come/Go Only with Activity
- Medication Use? Increasing Decreasing Not Helping Not taking

Mark an "X" on the lines below that best describes your response.

1. What activity causes the most pain / have most trouble performing?

Function: Rate your ability to perform the *above* activity.

| | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|-----------------|----|
| 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| | | | | | | | | | No restrictions | |

2. Pain at WORST: Rate your highest level of pain in past 72 hrs.

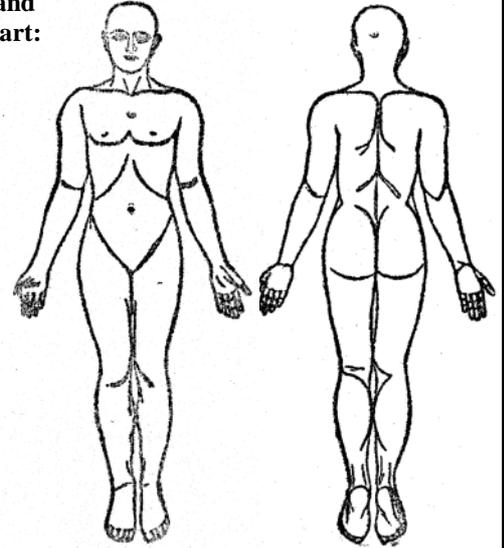
| | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|--------------------------|----|
| 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| | | | | | | | | | Worst pain Imaginable | |

3. Pain at BEST: Rate you lowest level of pain in past 72 hrs.

| | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|--------------------------|----|
| 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| | | | | | | | | | Worst pain Imaginable | |

Indicate the location and type of pain on the chart:

- Key:
 Ache/Dull: ^ ^ ^ ^
 Sharp/Stabbing: x x x x
 Numb / Tingling:
 Burning: = = = =
 Throbbing: / / / /
 Other Pain: - - - -



PATIENT SIGNATURE / PREPARED BY:

DATE

Provider Notes:

- See digital PT progress note in CHCS
- Patient ed. Completed. Patient verbalizes understanding and concurs with revised plan of care.

REVIEWED BY (Signature & Title)

DEPARTMENT/SERVICE/CLINIC
 LRMC Physical Therapy
 APO AE 09180 486-8263

DATE

PATIENTS IDENTIFICATION (For typed or written entries give: Name-last, first, middle; grade; rank; hospital or medical facility)

NAME (Last, First MI):

FMP / SSN (Sponsor): /

GRADE or RANK:

DOB:
 (Patients, dd-mmm-yyyy)

- | | |
|---|--|
| <input type="checkbox"/> HISTORY/PHYSICAL | <input type="checkbox"/> FLOW CHART |
| <input checked="" type="checkbox"/> OTHER/EXAMINATION OR EXAMINATION | <input type="checkbox"/> OTHER (Specify) |
| <input type="checkbox"/> DIAGNOSTIC STUDIES | |
| <input type="checkbox"/> TREATMENT | |

DA FORM 1 MAY 78 4700

MCEUH OP 370-R, APR 96(Rev)
 DA 4700 Medical Hx Follow Up Form - PFI update 7.doc, Updated 13-May-11

**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"/> |
| Rolling over in bed | <input type="checkbox"/> |
| Light to moderate work (standing, walking) | <input type="checkbox"/> |
| Heavy work (push/pulling, climbing, carrying) | <input type="checkbox"/> |
| Recreational activities | <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