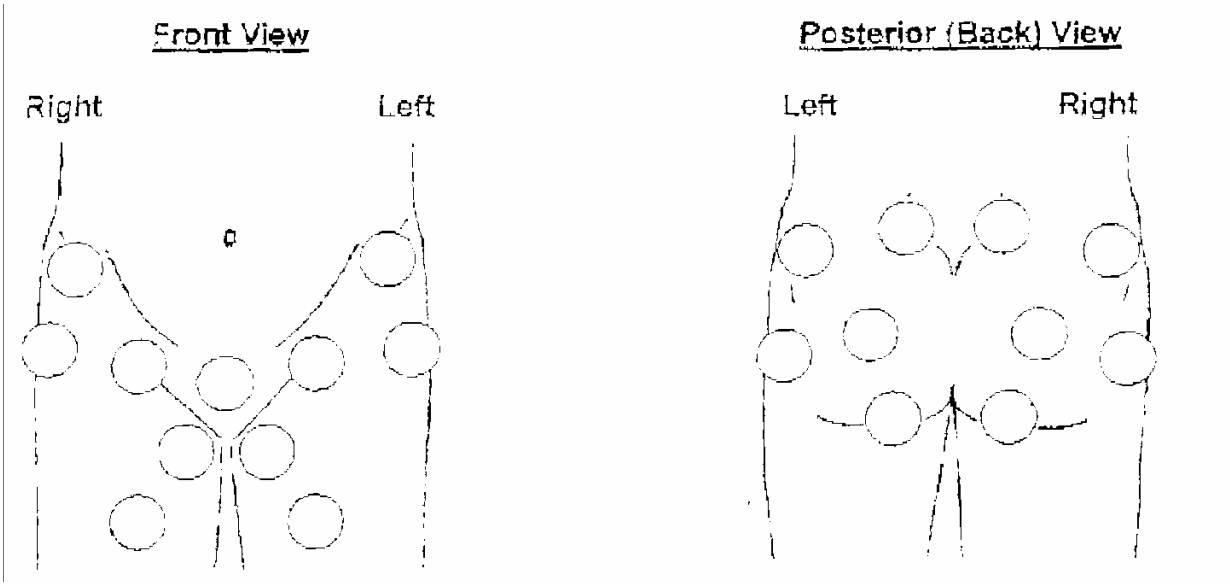
Post Injection Hip Pain Visual Survey

Date:
Name:
MRN:
DOB:

Fill out the following 1 to 4 hours after your injection, after going through motions that previously aggravated your symptoms.

Place an “X” in ALL of the circles where you are ***now*** experiencing your “hip” pain. Please bring this completed survey with you to clinic at your next visit.



Please bring this completed survey with you to the sports medicine clinic at your next visit.

(Official use only below this line)

Survey Context:

___ post Iliopsoas bursa injection (1 – 4 hours)

___ post hip arthrogram with anesthetic (1 -4 hours)

Which side, if any, was injected

___ Right

___ Left