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 checking 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.

SYMPTOMS.

These questions should be answered by thinking about your hip symptoms during the last week:

Do you feel grinding or hear clicking or any other types of noise from your hip?

- Never
- Rarely
- Sometimes
- Often
- Always

Difficulties spreading your legs wide apart

- Never
- Rarely
- Sometimes
- Often
- Always

Difficulties to stride out when walking?

- Never
- Rarely
- Sometimes
- Often
- Always

Can you bend your hip fully?

- Always
- Often
- Sometimes
- Rarely
- Never

STIFFNESS.

The following questions concern the amount of joint stiffness you have experienced during the last week in your hips. Stiffness is the sensation of restriction or slowness in the ease with which you move your hip joint.

How severe is your hip joint stiffness after first wakening in the morning?

- None
- Mild
- Moderate
- Severe
- Extreme

How severe is your hip stiffness after sitting, lying of resting later in the day?

- None
- Mild
- Moderate
- Severe
- Extreme

PAIN.

How often do you experience hip pain?

- Never
- Monthly
- Weekly
- Daily
- Always

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

Straightening your hip fully?

- None
- Mild
- Moderate
- Severe
- Extreme

Bending your hip fully?

- None
- Mild
- Moderate
- Severe
- Extreme

Walking on flat surface?

- None
- Mild
- Moderate
- Severe
- Extreme

Going up or down stairs?

- None
- Mild
- Moderate
- Severe
- Extreme

At night in bed?

- None
- Mild
- Moderate
- Severe
- Extreme

Sitting or lying?

- None
- Mild
- Moderate
- Severe
- Extreme

Standing upright?

- None
- Mild
- Moderate
- Severe
- Extreme

Walking on a hard surface (asphalt, concrete, etc.)

- None
- Mild
- Moderate
- Severe
- Extreme

Walking on an uneven surface?

- None
- Mild
- Moderate
- Severe
- Extreme
FUNCTION, DAILY LIVING.
The following questions concern you physical function. By this we mean your ability to move around and 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.

A1 Descending stairs?  
- None  
- Mild  
- Moderate  
- Severe  
- Extreme

A2 Ascending stairs?  
- None  
- Mild  
- Moderate  
- Severe  
- Extreme

A3 Rising from sitting?  
- None  
- Mild  
- Moderate  
- Severe  
- Extreme

A4 Standing?  
- None  
- Mild  
- Moderate  
- Severe  
- Extreme

A5 Bending to floor or picking up an object?  
- None  
- Mild  
- Moderate  
- Severe  
- Extreme

A6 Walking on flat surface?  
- None  
- Mild  
- Moderate  
- Severe  
- Extreme

A7 Getting in/out of car?  
- None  
- Mild  
- Moderate  
- Severe  
- Extreme

A8 Going shopping?  
- None  
- Mild  
- Moderate  
- Severe  
- Extreme

A9 Putting on socks/stockings?  
- None  
- Mild  
- Moderate  
- Severe  
- Extreme

A10 Rising from bed?  
- None  
- Mild  
- Moderate  
- Severe  
- Extreme

A11 Taking off socks/stockings?  
- None  
- Mild  
- Moderate  
- Severe  
- Extreme

A12 Lying in bed (turning over, maintaining hip position)?  
- None  
- Mild  
- Moderate  
- Severe  
- Extreme

A13 Getting in/out of bath?  
- None  
- Mild  
- Moderate  
- Severe  
- Extreme

A14 Sitting?  
- None  
- Mild  
- Moderate  
- Severe  
- Extreme

FUNCTION, SPORTS AND RECREATIONAL ACTIVITIES.
The following questions concern your physical function when being active on a higher level. The questions should be answered thinking of what degree of difficulty you have experienced during the last week due to your hip.

SP1 Squatting?  
- None  
- Mild  
- Moderate  
- Severe  
- Extreme

SP2 Running?  
- None  
- Mild  
- Moderate  
- Severe  
- Extreme

SP3 Jumping?  
- None  
- Mild  
- Moderate  
- Severe  
- Extreme

SP4 Twisting/pivoting on your injured hip?  
- None  
- Mild  
- Moderate  
- Severe  
- Extreme

QUALITY OF LIFE.

Q1 How often are you aware of your hip problem?  
- Never  
- Monthly  
- Weekly  
- Daily  
- Always

Q2 Have you modified your life style to avoid potentially damaging activities?  
- Not at all  
- Mildly  
- Moderately  
- Severely  
- Totally

Q3 How much are you troubled with lack of confidence in your hip?  
- Not at all  
- Mildly  
- Moderately  
- Severely  
- Extremely

Q4 In general, how much difficulty do you have with your hip?  
- Not at all  
- Mildly  
- Moderately  
- Severely  
- Extremely

Thank you very much for completing all the questions in this questionnaire.