

Name: _____

Date: _____

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).

	0 No Difficulty at All	1 Slight Difficulty	2 Moderate Difficulty	3 Extreme Difficulty	4 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"/>
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 the bath tub	<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 for 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"/>

Patient Signature

Date

Therapist Signature

Date

Name: _____

Date: _____

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

	0 No Difficulty at All	1 Slight Difficulty	2 Moderate Difficulty	3 Extreme Difficulty	4 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%

Not Graded:

Putting on socks and shoes	<input type="checkbox"/>					
Sitting for 15 minutes	<input type="checkbox"/>					

Scoring: The HOOS Tool is out of 17 possible responses, if the patient is unable to complete any task, check the N/A column so that it can be deducted from the overall total of responses when computing the mean. The total score for all items are summed and an average is taken based on the numbers of questions that were answered by the patient. Once a mean is obtained, multiple that by 100, and then divide by 4. Then you will take 100 minus that number achieved from the previous formula. A sample formula is shown below.

$$\frac{100 - [\text{mean} \times 100]}{4} = \text{ ______ } \% \text{ Function}$$

MEDICARE PATIENTS ONLY

$$100\% - \text{ ______ } \% \text{ Function} = \text{ ______ } \% \text{ Impairment}$$

Patient Signature

Date

Therapist Signature

Date