

Stinchfield Test

CLIENT INFORMATION

Name: _____ Date of examination: _____ dd / mm / yyyy
Date of birth: _____ dd / mm / yyyy Gender: _____
Sex: _____ Referring physician: _____

CLIENT'S MEDICAL HISTORY (IF NEEDED) NOTE: THE PATIENT'S MEDICAL HISTORY MUST ONLY BE PERTINENT TO HIP PAIN.

Symptoms:

Pain duration:

Previous hip pathologies:

Previous treatments/interventions:

TEST FINDINGS

Performed the modified test?

Yes No

Select one:

Positive: Elicited anterior or hip groin pain Negative: No pain in the groin or elsewhere

Pain description/location:

Observations/additional findings:

ADDITIONAL NOTES

Specify below: