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 PROCEDURE

Note: If applicable, you may modify the test by performing it with the patient's leg in slight external rotation. Have the patient in a supine position. Ask the patient to raise the affected leg, flexing the hip 20-30 degrees with the knee extended. Apply gentle pressure to the raised thigh, attempting to force it back down while the patient resists.

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: