Evolution PHYSIOTHERAPY

RUNNER'S CLINIC QUESTIONNAIRE

Name: _____ Date: _____
Age: _____ Gender: M / F

BASIC RUNNING INFO:
Years running: _____ □ Beginner □ Intermediate □ Elite
Currently running: # km/week: _____# runs/week:____ Team/Club/Coach (name):_____
Any changes in your training recently?
□ Volume □ Intensity □ Surface □ Shoes □ Orthotics
□ Stress/fatigue or other: _____
Do you wear orthotics? Yes ___ No ___, since _____, last modified_____

SHOES : □ PECH (regular, bulky) □ Minimalist □ Barefoot/Flats: _____

RACE INFO: Are you currently training for an event/race? □ Yes □ No
If **Yes**, which event/race (date, location, distance) _____
Have you trained for this type of event/race before? □ Yes □ No
Races: _____

PAIN/INJURIES:
Are you currently experiencing pain during or after a run? □ Yes □ No
If **Yes**, where is your pain located? _____
Have you been assessed by: □ a physician, □ a chiropractor, □ a physiotherapist for this pain? _____
Have you had any treatment for this pain? □ Massage Therapy, □ Physiotherapy, □ Chiropractor, □ Other:
_____

Please list previous injuries due to running or other trauma:
1: _____
2: _____

Please list your expectations/goals from the Runner's Clinic:
1. _____
2. _____

Running health/safety screen:
Have you ever had any of the following?
Loss of consciousness, dizziness, chest pains, heart palpitations with running/effort? Yes ____ No ____
Difficulty breathing or coughing associated with running/effort? Yes ____ No ____
Heat related problems (dehydration, heat stroke, muscle cramping)? Yes ____ No ____
Problems with weight control or eating? Yes ____ No ____
Have you ever run on a treadmill? Yes ____ No ____
Please list other current activities/hobbies/sports:
_____

Please indicate how you learned about our clinic and our running gait assessments:
□ Presentation □ Doctor □ other health professional □ friend/family □ Internet □ sign/add
If you were referred by someone: _____