foundation REHABILITATION SERVICES

3D RUNNING & GAIT ANALYSIS INTAKE FORM

Date (mm/dd/yyyy): _____

Last Name: _____ First Name: _____

DOB (mm/dd/yyyy): _____ Sex: ☐ Male ☐ Female Height: _____ Weight: _____

Leg dominance (which leg do you kick with?): ☐ Left ☐ Right

Current activities:

If running is one of your current activities, please answer the following as thoroughly as possible:

You are a: ☐ Competitive Runner ☐ Recreational Runner ☐ New Runner

How many years have you been running? _____ Years running consistently? _____

Are you part of a Running Club/Group? ☐ No ☐ Yes Name: _____

Current training: (Please describe your typical training week in the last month)

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Distance							
Time							
Type of Run							
Surface							
Shoes							
Cross Training							

Personal Bests: Distance: _____ Time: _____ Year: _____ Distance: _____ Time: _____ Year: _____

How many races do you run a year at your typical distance? _____

What are your race or personal running goals?

_____

_____

Please describe any recent changes in training volume, intensity, surface, hills, running shoes, fatigue/stress, body weight, hormones or general health?

_____

_____

Do you wear foot orthoses: ☐ Yes ☐ No, since _____, for _____

Please list any other sports or activities you regularly participate in: _____

_____

Present injuries or symptoms: (Where applicable)

Location 1: _____Length of time: _____

Pain at rest (/10): _____ Pain while running (/10): _____ Pain after running (/10): _____ lasting _____

Location 2: _____Length of time: _____

Pain at rest (/10): _____ Pain while running (/10): _____ Pain after running (/10): _____ lasting _____

Location 3: _____Length of time: _____

Pain at rest (/10): _____ Pain while running (/10): _____ Pain after running (/10): _____ lasting _____

Please check which statements apply to you:

- ☐ I continue to train in pain
- ☐ I have missed training due to my pain
- ☐ I have changed my training volume or intensity due to pain

If you checked more than one statement, which BEST describes how your injury affects your training?

_____

Have you seen a medical professional for this problem? ☐Yes ☐No If so, what type of practitioner/s?

_____

Describe any treatments you have received: _____

Medical Info:

Are you taking any drugs (prescribed or not) and/or supplements (vitamins, minerals, protein)?

☐Yes ☐No _____

Do you regularly take non-steroidal anti-inflammatory drugs (NSAIDS i.e. ibuprofen) before or after running?

☐Yes ☐No _____

Do you have a family history of sudden death before the age of 50?

☐Yes ☐No Relationship: _____

Have you lost consciousness, felt dizzy, felt thoracic pain or palpitations during physical activity? ☐Yes ☐No

Do you have trouble breathing? ☐Yes ☐No Do you cough during physical activity? ☐Yes ☐No

Have you ever suffered from dehydration, heat stroke, muscle cramping? ☐Yes ☐No

Do you have a chronic disease or medical condition that requires medical care?

☐Yes ☐No _____

Do you have concerns about your weight or diet?

☐Yes ☐No _____

Do you have concerns about your menstrual cycle or pelvic floor?

☐Yes ☐No _____

If female, are you pregnant? ☐Yes ☐No