



### 3D RUNNING & GAIT ANALYSIS INTAKE FORM

Date (mm/dd/yyyy): \_\_\_\_\_

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_

DOB (mm/dd/yyyy): \_\_\_\_\_ Sex:  Male  Female  Non-Binary 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:  No  Yes, 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