



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