Injury Screening
Runner Questionnaire

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Today's Date: _____

Name:_____ Email Address:_____ Phone:_____

Age: _____ Height: _____ Weight:_____

Briefly describe symptoms and how they occurred (include what aggravates your symptoms): _____

_____

_____

Date of Onset: _____ Previous treatment for this injury: _____

Past orthopedic injuries: _____

Medical problems (ex. diabetes, asthma, cardiac problems, arthritis etc) _____

_____

Past surgeries (orthopedic or otherwise relevant): _____

_____

Medications: _____

Running/Walking Summary

# of years running/walking: _____ Current weekly mileage: _____ Current long run/walk mileage:_____

# of track workouts per week: _____ # of hill workouts per week: _____

Avg. # of consecutive days run in the past month: _____ Running surface: _____

Brand of training shoes: _____ Age of shoes: _____ Orthotics? Yes/No Type: _____

What are your running/walking goals? _____

Training

Cross training methods and frequency: _____

Stretching frequency (circle): daily frequently sometimes never

List any stretches you currently do: _____

_____

Strength training frequency (circle): daily frequently sometimes never

List any strength training exercises you currently do (include core training): _____

_____

What would you like to gain from this session?
_____ Injury treatment advice _____ Exercise training advice _____ Footwear advice