



Run Fast PT Running Evaluation Form

Name: _____ Email: _____

Background

What brings you here? _____

When did the current problem begin? _____

How did it happen? _____

Do you have pain *while* running? ☐ Yes ☐ No If so, what happens to the pain while running? ☐ increases ☐ decreases

Do you have pain *after* running? ☐ Yes ☐ No If so, how long does it last? ☐ < 1 hr ☐ 1-2 hrs ☐ 2-6 hrs ☐ 6+ hrs

Does anything alleviate the problem? ☐ medication ☐ rest ☐ stretching ☐ heat/cold ☐ other: _____

Past Injuries	Right	Left	Running related		Right	Left	Running related
Low back pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	compartment syndrome	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Iliotibial band syndrome	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	achilles tendonitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Knee pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	plantar fasciitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stress fracture	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Shin splints	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				

Current medications: ☐ aspirin ☐ advil/motrin/ibuprofen ☐ tylenol ☐ bronchodilators

☐ vitamin D ☐ calcium ☐ others: _____

Training

Years running _____ How would you classify your level of running? ☐ recreational ☐ competitive

Volume: _____ miles/week _____ days/week _____ months/year Pace: _____ min/mile

Speed work: ☐ yes ☐ no Hill Repeats: ☐ yes ☐ no Warm-up: ☐ Yes ☐ No Cool-down: ☐ Yes ☐ No

Stretching: ☐ before run ☐ After run ☐ throughout day ☐ none

Typical racing distance: ☐ 400 meters-3000 meters ☐ 5-10k ☐ ½ marathon ☐ marathon ☐ ultra's ☐ triathlon ☐ other

What foot-strike pattern to you use? ☐ rearfoot ☐ midfoot ☐ forefoot ☐ unsure

Footwear

Shoe/brand model: _____ Shoe age: _____ months Are your shoes comfortable? ☐ yes ☐ no

Orthotic/insert? ☐ Yes ☐ No If yes: ☐ custom ☐ over the counter Heel Lift: ☐ right ☐ left ☐ none

Running Motivation and Goals

What is the primary reason you run? ☐ general fitness ☐ weight control ☐ stress control ☐ social reasons ☐ competition

What are your running goals? Check all that apply.

☐ continue at current level ☐ increase running to higher level

☐ compete in specific race distance: _____ date: _____

☐ other: _____