RUNNING GAIT ANALYSIS HEALTH HISTORY

Name:_____Date:_____

To insure you receive a complete and thorough evaluation, please provide us with important background information on the following form. If you do not understand the question or require assistance, please speak with your fit specialist. Thank you.

GENERAL HEALTH

How would you rate your general health?
O Excellent O Good O Average O Fair O Poor

Do you smoke? O Yes,____packs/day O No O Quit

What is your stress level? O Low O Medium O High

How many hours of sleep do you get per night?_____

Menstrual cycle frequency (if applicable):_____

Height:_____ Weight:_____

Please list all medications (Prescription and over the counter) that you are taking:_____
_____

Are you currently under the care of any health care provider?: O Yes / O No If yes, who:_____
_____

PAST MEDICAL HISTORY

Have you ever had/been diagnosed with any of the following conditions? (Check all that apply):

O Heart disease	O Women's health issue
O High/low blood pressure	O Cancer
O Stroke / CVA	O Lung disease/ asthma
O Blood disorders / anemia	O Diabetes
O Arthritic condition	O Epilepsy / seizures
O Kidney disease	O Thyroid disease
O Osteoporosis	O Allergies:_____
O Auto-immune disorder	O Brain injury/disorder
O Orthopedic issue	O Depression
O Poor circulation	O History of Blood clots
O Pacemaker/defibrillator	O Recent infection
O Bowel/Bladder issue	O Immunosuppression
O Pregnancy:#_____	O Chemical dependency
O Infectious disease (Hepatitis, TB, HIV, etc)	O Other:_____ _____

Please list any recent/relevant past surgeries or other medical history:_____
_____

Previous Running Injuries / Treatments:_____
_____

RUNNING

Miles / Week (current and average):_____

Long Run Distance / Week:_____

# of Runs / week:_____

Pace: Mile:_____Tempo run:_____Long Run:_____

Terrain of runs: _____

Brand / Style of running shoes: _____
Reason for shoe:_____
Orthotic Use: O Yes / O No

Do you engage in any form of cross training? O Yes/O No
If yes, which activities / frequency?_____
_____

Do you engage in strength training? O Yes/O No
If yes, which activities / frequency?_____
_____

Do you have pain while running? O Yes / O No
If yes, describe:_____
Would you be interested in a physical therapy consult to address any of these concerns? O Yes / O No

GOALS / REASONS FOR RUNNING EVAL

1._____
2._____
3._____

SIGNATURE:_____