

Runner Evaluation Form



Name: _____ Date of Birth: _____

Training History:

1. How long have you been running (months/years)? _____

2. How is your running scheduled?

☐ Coach ☐ Generic program ☐ Do your own thing

Other/details: _____

3. Running volume (km's per week), or if injured, pre-injury volume?

4. Number of runs per week? _____

5. Longest weekly run? _____

6. Do you do any interval sessions, tempo/threshold runs or fartlek? ☐ Yes ☐ No

7. How consistent are you with your training?

☐ Very ☐ Not at all ☐ Somewhat

8. How do you organise your weekly training effort?

☐ All runs at about the same effort ☐ Mostly easy runs, with some harder runs/sessions

☐ Most runs at moderate to high intensity/effort ☐ Other: _____

9. Training for an event? ☐ Yes ☐ No If yes, which event/s? _____

10. What are your short and long term running goals, if any? _____

11. Level of competition:

☐ Recreational only ☐ Recreational competitive ☐ Competitive ☐ Elite

Other Activities:

1. Other sports or cross training? ☐ Yes ☐ No Details: _____

2. Do you do any strength training (home or gym etc.)? ☐ Yes ☐ No Details: _____

3. Do you get regular massage or perform any regular self-massage (e.g. foam rolling)? ☐ Yes ☐ No Details: _____

Running Shoe & Orthotic History:

1. What model(s) of running shoes do you train and/or race in? _____

2. How long have you had your current pair(s) of shoes? _____

3. Did you self-select your running shoes or did you go somewhere that provided a fitting service?

4. Do you wear orthotics? ☐ Yes ☐ No

If yes:

How long have you worn them? _____

Why did you first start wearing them? _____

What effect do they have? _____

Injury History:

1. Are you currently injured? ☐ Yes ☐ No

*If no, please skip to **Previous Running Related Injury** section*

If yes:

2. Are you still running or have you stopped or cut back due to injury? _____

3. Were symptoms initially brought on by running? ☐ Yes ☐ No
If no, how did you develop the injury: _____
4. Is this a new or reoccurring injury? ☐ New ☐ Reoccurring
5. How long have you had the current symptoms? _____

6. When did you first notice pain (e.g. half way through a long run)? _____

7. Please describe your symptoms (location/right side/left side?): _____

8. Type of pain: ☐ Dull ☐ Sharp ☐ Throbbing ☐ Intermittent ☐ Constant ☐ Burning ☐ Bruise

☐ Numbness or Pins and Needles ☐ Other: _____

9. Onset: ☐ Gradual ☐ Sudden

10. When does it hurt? ☐ Running ☐ Stairs ☐ Hills ☐ Walking ☐ Night or when at rest

Other: _____

11. When you run, when do your symptoms occur?

☐ Every step of the run

☐ Worse towards the end of the run

☐ Worse at start & then improves

☐ After the run ends (e.g. next day)

12. What helps relieve your symptoms? _____

13. What increases your symptoms? _____

14. Do any of your shoes make the problem better or worse? ☐ Yes ☐ No ☐ Not sure Details: _____

15. Any recent changes?

☐ Increased weekly volume

☐ Speed or track work

☐ More hills

☐ Change in terrain

☐ New shoes (runners or casual/work)

☐ Change in running technique

☐ New occupation or occupational duties

☐ Started a new sport

Other/details: _____

16. Did you have another injury or discomfort in your feet or legs prior to your injury that you tried to train through? ☐ Yes ☐ No

If yes, provide details: _____

17. Are you taking medication for current symptoms? ☐ Yes ☐ No

Details (type and frequency): _____

18. Have you seen, or are you still seeing any other health professional for your current injury? ☐ Yes ☐ No

19. What do you feel is the most likely cause/s of your current injury? _____

Previous Running Related Injury:

Have you ever had any of the below?

- | | |
|--|--|
| <input type="checkbox"/> Patellofemoral pain syndrome (front of knee pain) | <input type="checkbox"/> chronically sore or tight muscles |
| <input type="checkbox"/> Iliotibial band (ITB) syndrome | <input type="checkbox"/> Calf strain |
| <input type="checkbox"/> Stress fracture/s | <input type="checkbox"/> Forefoot pain |
| <input type="checkbox"/> Plantar fasciitis | <input type="checkbox"/> Lower back pain |
| <input type="checkbox"/> Arch pain | <input type="checkbox"/> Hip/Glute pain |
| <input type="checkbox"/> Shin pain | <input type="checkbox"/> Inner or outer ankle pain |
| <input type="checkbox"/> Achilles tendinopathy | |

Please list other injuries or details of above:

Medical History:

1. Previous acute injury/trauma (e.g. sprained/ruptured ligament, meniscus injury etc.)? ☐ Yes ☐ No

Details:

2. Previous surgeries? ☐ Yes ☐ No Details: _____

3. Recent weight gain or loss? ☐ Yes ☐ No Details: _____

4. Recent dietary changes? ☐ Yes ☐ No Details: _____

5. Known or potential eating disorder? ☐ Yes ☐ No

6. Have you recently been feeling more tired/fatigued than usual? ☐ Yes ☐ No

7. Have you been feeling stressed or anxious recently? ☐ Yes ☐ No

8. Any changes to sleeping habits (e.g. duration or quality reduced)? ☐ Yes ☐ No

9. Female History: ☐ N/A

Regular Periods: ☐ Yes ☐ No

Age of 1st Period: _____

Pregnant: ☐ Yes ☐ No

You're done!

Thanks for taking the time to fill out this form. It helps us to make sure we don't miss anything important related to your running and injury history.

Please bring with you to the initial appointment:

- Running shoes and shorts/tights for a biomechanical assessment
- Any Imaging (e.g. x-ray, ultrasound or MRI) that may be of relevance
- Health fund card if you are covered for podiatry – we have HICPAS facilities for on-the-spot rebates

Please allow around 1 hour for your initial appointment.