STRIDE STRONG
PHYSICAL THERAPY

Name: ______________________ Age: ________ Height: ________ Weight: ________

Gender: ☐ Male ☐ Female Running Team (if applicable): ____________________

How did you hear about us? ☐ physician ☐ physical therapist ☐ friend

☐ internet/website ☐ brochure ☐ running club ☐ other: ________

May we follow-up with you by phone or email? ☐ yes ☐ no 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? ☐ < 1hr ☐ 1-2 hrs ☐ 2-6 hrs ☐ 6+ hrs

Does anything alleviate the problem? ☐ medication ☐ rest ☐ heat/cold

☐ stretching ☐ other: ____________________

Does anything worsen the problem? ☐ activity ☐ other: ____________________

<u>Past Injuries</u>

	Right	Left	Running related		Right	Left	Running related
Shin splints	☐	☐	☐	Muscle injury	☐	☐	☐
Stress fracture	☐	☐	☐	Ligament injury	☐	☐	☐
Achilles tendonitis	☐	☐	☐	Dislocation	☐	☐	☐
Plantar fasciitis	☐	☐	☐	Tendonitis/bursitis	☐	☐	☐
IT Band Syndrome	☐	☐	☐	Fracture	☐	☐	☐
Knee pain	☐	☐	☐	Low back pain	☐	☐	☐
Compartment Syndrome	☐	☐	☐	Other	☐	☐	☐

<u>Current medications:</u> ☐ aspirin ☐ admil/motrin/ibup. ☐ tylenol ☐ vitamins

☐ inhaler ☐ other: ____________________________

List any nutritional supplements you are taking: ____________________________

Running goals

☐ continue running at current level ☐ increase running to higher level

☐ compete in particular race:______________________________ ☐ other: ______________________________

TRAINING

Years running: ____ Pace: __________ min/mile

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

Volume: _____ miles/week _____ days/week ______ months/year

How much does your volume increase each week? ☐ 0% ☐ 5-10% ☐ 10-15% ☐ 15-20% ☐ > 20%

Speed work: ☐ yes ☐ no Hills: ☐ yes ☐ no

Warm-up: ☐ yes ☐ no Cool-down: ☐ yes ☐ no

Stretching: ☐ before run ☐ during run ☐ after run ☐ throughout day

Typical running distance: ☐ 5K ☐ 8K ☐ 10K ☐ Other: _________________

☐ ½ marathon ☐ marathon ☐ ½ triathalon

☐ triathalon

ADDITIONAL FACTORS

Shoe age: _______ months Shoe brand/model: ____

Are your shoes comfortable? ☐ yes ☐ no

Heel lift: ☐ right ☐ left ☐ none

Orthotics: ☐ yes ☐ no If yes: ☐ custom ☐ over the counter

Water/sports drink use: ☐ before run ☐ during run ☐ after run

Do you consider yourself: ☐ underweight ☐ overweight If so, how much? ________________

Are you using a special diet? ☐ yes ☐ no If so, describe: __________________________

Would you like a consultation with a sports nutritionist? ☐ yes ☐ no

STRIDE STRONG PHYSICAL THERAPY LLC

MEDICAL HISTORY QUESTIONNAIRE

The purpose of this questionnaire is to help us understand your health status. Please complete this form and your therapist will answer any questions during your exam. This form is considered part of your medical record.

Name: ____ Birth Date/Age: ____________________ / ___________

Referring Physician: ____________________________________ Family Physician: _______________________________

Emergency Contact Name: ______________________________ Phone/Cell: ____________________________________

Occupation & Employer:_________________________________ Currently working? ______________________________

Have you had surgery for this injury? YES NO

Type of surgery/dates: ____

Is an attorney involved in this case? YES NO Attorney Name: ____

Are you currently taking any prescription or non-prescription medications? YES NO

Anti-Inflammatories Muscle Relaxers Pain Medicines Others: _______________________________

Have you had any of the following Medical or Rehabilitative Care for this Injury/Episode?

	Yes	No		Yes	No
Chiropractor	___	___	CT Scan	___	___
General Practitioner	___	___	EMG/NCV	___	___
Occupational Therapy	___	___	MRI	___	___
Physical Therapy	___	___	Myelogram	___	___
Massage Therapy	___	___	X-Rays	___	___
Neurologist	___	___	Emergency Room Care	___	___
Orthopedist	___	___	Podiatrist	___	___

Do you now have, or have you ever had, any of the following?

	YES	NO		YES	NO
Asthma, Bronchitis, or Emphysema	___	___	Severe or Frequent Headaches	___	___
Shortness of Breath/Chest pain	___	___	Vision or Hearing difficulty	___	___
Coronary Heart Disease or Angina	___	___	Numbness or tingling	___	___
Do you have a Pacemaker	___	___	Dizziness or Fainting	___	___
High Blood Pressure	___	___	Weakness	___	___
Heart Attack/Surgery	___	___	Weight loss/Energy loss	___	___
Blood clot/emboli	___	___	Hernia	___	___
Stroke/TIA	___	___	Epilepsy/Seizures	___	___
Allergies	___	___	Thyroid trouble/Goiter	___	___
Pins or Metal Implants	___	___	Incontinence	___	___
Joint replacement (any)	___	___	Bowel or bladder problems	___	___
Diabetes	___	___	Neck Injury/Surgery	___	___
Infectious diseases	___	___	Shoulder Injury/Surgery	___	___
Cancer/Chemotherapy/Radiation	___	___	Elbow/Hand Injury/Surgery	___	___
Arthritis/Swollen joints	___	___	Back Injury/Surgery	___	___
Osteoporosis	___	___	Knee Injury/Surgery	___	___
Sleeping problems/difficulty	___	___	Leg/Ankle/Foot Injury/Surgery	___	___
Do you smoke?	___	___	Multiple Sclerosis	___	___
Latex Sensitivity/Allergy	___	___	Parkinson’s Disease	___	___

Additional comments: ____

FOR WOMEN ONLY:	YES	NO		YES	NO
Pelvic Inflammatory disease	___	___	Endometriosis	___	___
Irregular Menstrual Cycle	___	___	Incontinence (urinary/fecal)	___	___
Complicated pregnancies/deliveries?	___	___	Are you pregnant?	___	___

Patient/Guardian Signature: ____ Date: ____________________________

PT Initials: _________________ Date: _________________