the manual touch
PHYSICAL THERAPY
WHOLE BODY APPROACH TO HEALTH

RUNNING INTAKE FOR SCREEN/ANALYSIS

Name:_____ Age:_____ Date:_____

Occupation:_____

If student, where and what grade/year?_____

What brings you here?:_____

_____

_____

When did issue begin?:_____

How did it happen?:_____

_____

_____

Do you have pain while running? ____yes ____no

If so what happens to the pain while running?____ increases _____decreases

At what point in the run do you have pain or when does it go away?_____

_____

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: _____

Does anything worsen the problem?: _____activity _____ other: _____

Past running/activity related injuries:

Shin splints	Knee pain	Tendonitis/bursitis	Other
Stress fx	Compartment syndrome	Fracture	Dislocation
Achilles tendonitis	Muscle injury	Low back pain	
Plantar fasciitis	Ligament injury	Iliotibial band syndrome	

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Running goals:_____

_____

_____

_____

Training:

Years running:_____

How would you classify your level of running?: ____recreational _____ competitive

Volume: _____miles/week _____days/week Pace: _____min/mile

Speed work: _____ yes _____ no Hills: ____yes _____no

cross training, if so, what & how often?_____

Typical race distance: (list all)_____

_____

Name/model running shoe: _____

Orthotics: _____yes _____no

Are you a triathlete?_____yes_____no

If so, how often/miles do you bike/week?_____

Any issues?_____

_____

_____

How often do you swim and distance/week?_____

Any issues?_____

_____

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Past Medical History: please circle any that pertain & elaborate as needed on back of page

Alcoholism	Eyes, ears, nose, throat problems	Neurological disorder
Allergies	Fibromyalgia	Osteopenia/osteoporosis
Arthritis	Food intolerance (be specific)	Respiratory problems
Asthma	Fractures (be specific)	Seizure disorder
Autoimmune disease (be specific)	GI issues (be specific)	Skin problems
Back Pain	Headaches	Stroke
Cancer	Heart Disease	Swelling
Chronic Fatigue	HIV	Thyroid
Circulatory problems	High blood pressure	Traumatic brain injury(TBI)
Depression	Kidney or Bladder issues	MEN: Prostate issues other
Diabetes	Learning Disabilities	WOMEN: Endometriosis
Dizziness/vertigo	Liver or Gallbladder disease	Menstruation issues
Drug Addiction	Lymphedema	Fibroids/cysts
Eating disorder	Mental Illness	other
Environmental sensitivities	Musculoskeletal problems	

List all surgeries & when they occurred:_____

_____

List all traumas & when they occurred:_____

_____

Anything else you want to tell me:_____

_____