the manual touch
PHYSICAL THERAPY
WHOLE BODY APPROACH TO HEALTH

Running Intake

Name:_____ Age:_____ Date:_____

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

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 injuries:

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

Running goals: _____

Training:

Years running:_____

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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?_____

_____