RUNNER’S EVALUATION FORM

Patient Name: _______________________________ Date of Birth: ____/____/____ Sex: ________

MD (if applicable): ___________________________ Diagnosis: __________________________________

Chief complaint(s): ________________________________________________________________________

What brings you here?

______________________________________________________________________________________

______________________________________________________________________________________

What do you understand to be the nature of your problem and how did you arrive at this perspective?

______________________________________________________________________________________

______________________________________________________________________________________

How concerned are you about your situation? (0 = not concerned at all, 10= distraught)

0 1 2 3 4 5 6 7 8 9 10

What specifically aggravates your pain/Sx?

______________________________________________________________________________________

______________________________________________________________________________________

What do you instinctively do to alleviate your pain/Sx?

______________________________________________________________________________________

______________________________________________________________________________________

How would you best describe yourself as a runner? Recreational Competitive Elite Professional

How many yrs have you been running? 1 2 3 4 5+ How many days/week do you run? 1 2 3 4 5 6 7

Avg weekly mileage? 0-10 10-20 20-30 30-50 50-75+ Races finished to date (if any)? 5K 10K 13.1 26.2 50K+

What surface(s) do you primarily run on? Road/asphalt Treadmill Trail Track

What sports or activities do you participate in, or have participated in beyond running?

<table>
<thead>
<tr>
<th>Cycling</th>
<th>Swimming</th>
<th>Hockey</th>
<th>Soccer</th>
<th>Baseball</th>
<th>Softball</th>
<th>Basketball</th>
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</thead>
<tbody>
<tr>
<td>Hiking</td>
<td>Lacrosse</td>
<td>Tennis</td>
<td>Weights</td>
<td>Yoga</td>
<td>Pilates</td>
<td>Tai Chi</td>
</tr>
<tr>
<td>Other:</td>
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</tbody>
</table>

What type of shoe do you use for most of your training? Barefoot Minimalist Neutral Stability Motion Control

Do you train in more than one pair of running shoes? Y N If so, how many different pairs? 2 3 4+

What make & model? ________________________________________________________________

Do you use shoe inserts/orthotics? Y N Length of Use (yrs): 1 2 3 4 5+

Do you have a history of stress fractures? Y N If so, what location(s)? __________________

Do you have a history of steroid use? Y N If so, when & for what? ____________________

Name: _______________________________ Date: __________________________
Females:
Do you have regular menstrual cycles? Y N How old were you at the time of your first menstruation? 
Are you pregnant or is there a chance of you being pregnant? Y N
Have you ever been started on birth control pills for reasons other than birth control? Y N
Any Hx of disordered eating or eating disorders? Y N Any Hx of urinary incontinence or urgency? Y N
Have you ever received a cortisone or platelet rich plasma (PRP) injection? Y N
If so, when and what location? Date: Location:
Avg number of hrs of sleep per night? <4 5-7 8-10+ Avg number of hrs spent sitting per day? <2 3-5 6-8 9-12+

Which Statement Best Describes Your Pain?
1. I only experience pain when I run.
2. I experience pain when I run that tends to linger even after I stop running.
3. The pain that I’m experiencing interferes with routine activities of daily living (ADLs)
4. The pain that I’m experiencing causes me to avoid routine ADLs.
5. The pain that I’m experiencing prompts me to take medications.
6. The pain that I’m experiencing makes getting through the day difficult.

Cardiovascular Screening Checklist:
Personal History:
1. Chest pain/discomfort/tightness/pressure related to exertion? Y N
2. Unexplained syncope? Y N
3. Excessive exertional & unexplained dyspnea/fatigue or palpitations associated with exercise: Y N
4. Prior recognition of a heart murmur? Y N
5. Elevated systemic blood pressure? Y N
6. Prior restriction from participation in sports? Y N
7. Prior testing for the heart ordered by a physician? Y N

Family History:
1. Premature death before 50 due to heart disease in ≥1 relative? Y N
2. Disability from heart disease in close relative <50 y/o? Y N
3. Any specific knowledge of cardiac conditions in family members? Y N
   a. If so, list here:

Diagnostics: X-rays MRI Bone Scan CT Scan Ultrasound Other

Medications:

Within the past month, have you experienced a negative/stressful life event that has created a series of challenges? Y N

Have you experienced any of the following in the last few weeks?
Recent Weight Loss: Y N Change in Bowel/Bladder: Y N Night Pain: Y N

Past Medical History:
1. 2.
3. 4.
5. 6.

Is there anything else that you feel like we may have missed or that you would like for me to know to be in the best possible position to help you and what would you like to get out of our time together?

Name: __________________________ Date: __________________________
OBJECTIVE:

Appearance:__________________________________________________________

Height:______ Weight:______ Resting HR:______ bpm BP:______ mm Hg

Auscultation Findings:__________________________________________________

Gait:
WNL   Antalgic   Assistive Device: Y N   Type (if applicable): ________________

Heel Walking: L: +/- R: +/-   Toe Walking: L: +/- R: +/-

Lower Quarter Screen:

Inspection:____________________________________________________________

Dermatomes:___________________________________________________________

Myotomes:____________________________________________________________

DTRs & UMN Tests

Achilles
L: UTE 1+ 2+ 3+ 4+   R: UTE 1+ 2+ 3+ 4+

Patellar Tendon
L: UTE 1+ 2+ 3+ 4+   R: UTE 1+ 2+ 3+ 4+

Babinski
L: +/-   R: +/-

Ankle Jerk
L: +/-   R: +/-

Passive SLR:
L:____ ° R:____ °

Passive SLR + DF:
L:____ ° R:____ °

Slump Test:
L:___________________________________________________________ R:_________

Toe Dexterity:
L: Isolated great toe dorsiflexion: Y N   R: Isolated great toe dorsiflexion: Y N

Isolated lesser toe dorsiflexion: Y N   Isolated lesser toe dorsiflexion: Y N

Splaying: Y N   Splaying: Y N

Swelling:
Ankle Figure Eight
L:____ cm   R:____ cm

Knee Effusion/Milk Test
L: 0 trace 1+ 2+ 3+   R: 0 trace 1+ 2+ 3+

ROM, MMT, & Special Tests:

<table>
<thead>
<tr>
<th>Motion</th>
<th>Left</th>
<th>Right</th>
<th>MMTs</th>
<th>Left</th>
<th>Right</th>
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<tr>
<td>Hip flexion</td>
<td></td>
<td></td>
<td>Seated hip flexion</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hip ER/IR</td>
<td></td>
<td></td>
<td>Sidelying hip abduction</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Knee Flex-Ext</td>
<td></td>
<td></td>
<td>Seated hip external rotation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ankle DF (Prone @ 90)</td>
<td></td>
<td></td>
<td>Prone Knee flexion @ 90</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hip ABD/ER</td>
<td></td>
<td></td>
<td>Prone Knee flexion @ 60</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Great Toe DF</td>
<td></td>
<td></td>
<td>Prone Knee flexion @ 30</td>
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</tbody>
</table>

Name: ___________________________ Date: ________________________
**Additional Testing:**

**Single Leg Balance**
What side does the runner initiate with? L R
Compensations:
Left: ____________________________ Right: ____________________________

**Standing Forward Flexion AROM:**
Fingertips to knees  Fingertips to shins  Fingertips to ankles  Fingertips to toes  Palms to floor

**Lateral Step Down:**
*Perform 10x on each side
Left
Pain: Y N  Location:
Strategies: Toes out  Femoral IR  Dynamic Valgus  Arm Strategy  Hip Strategy  Trunk Strategy
Right
Pain: Y N  Location:
Strategies: Toes out  Femoral IR  Dynamic Valgus  Arm Strategy  Hip Strategy  Trunk Strategy

**Free Standing Squat:**
*Perform three to five times
Left
Pain: Y N  Location:________________________
Depth: Above parallel  Parallel  Below Parallel
Right
Pain: Y N  Location:________________________
Depth: Above parallel  Parallel  Below Parallel

**Single Leg Calf Raises**
Left:________________________
Pain: Y N  Location:________________________
Right:________________________
Pain: Y N  Location:________________________

**Single Leg Hopping:**
*Perform 20-30x on each leg
Left
Pain: Y N  Location:________________________
Right
Pain: Y N  Location:________________________

**Shoe Screen:**

<table>
<thead>
<tr>
<th>Shoe Screen</th>
<th>Left</th>
<th>Right</th>
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<tbody>
<tr>
<td>Symmetry</td>
<td>Y N</td>
<td>Y N</td>
</tr>
<tr>
<td>Break Test</td>
<td>Y N</td>
<td>Y N</td>
</tr>
<tr>
<td>Twist Test</td>
<td>Y N</td>
<td>Y N</td>
</tr>
</tbody>
</table>

**Additional Notes**

**Joint Mobility Assessment:**

**Special Tests:**

**Treadmill Running Analysis:**
Preferred training speed:_____ mph  Strike pattern: Rearfoot  Midfoot  Forefoot
Step Rate:_____ spm  Overstriking: Y N
Additional Notes:________________________

Name: ____________________________ Date: ____________________________
**ASSESSMENT:**

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

Comorbidities:  

**STGs:**
1.  
2.  
3.  

**LTGs:**
1.  
2.  
3.  

**PLAN:**

<table>
<thead>
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<th>Pain education</th>
<th>Therapeutic activities</th>
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<tr>
<td>Customized HEP</td>
<td>Manual techniques</td>
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<tr>
<td>Therapeutic exercises</td>
<td>Neural mobilization</td>
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<tr>
<td>Neuromuscular re-education</td>
<td>Modalities</td>
</tr>
<tr>
<td>Gait retraining</td>
<td>Refer out</td>
</tr>
</tbody>
</table>

**Frequency** (per week):  1  2  3  

**Duration** (wks.):  0-2  2-4  4-6  6-8  8-10  10+  

Therapist Name: ______________________  
Signature: ______________________  
License No: ______________________  
NPI: ______________________  

Name: ______________________  
Date: ______________________  

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