



Runner Evaluation Questionnaire

Name: _____

Date: _____

DOB: _____

Run Team/Club _____

Part 1: Training

How often do you perform the following during an average week:

1. Run more than 15 minutes: _____
2. Lift weights: _____
3. Perform a dynamic warm-up: _____
4. Foam rolling, lacrosse ball, stick, or self massage: _____
5. Any other form of cardio exercise for 20 minutes or more: _____
6. How many hours per night do you sleep? _____
7. Highest mileage/week: _____ Current mileage/week: _____ Typical pace: _____

Detail a typical training week (distance and average pace).

Easy runs	Long run	Interval/hill repeat	Tempo/pace

Goal Race(s): _____

PB's (year obtained): _____

Training shoe: _____

Racing shoe: _____



Part 2: Injury History

Have you had any imaging performed in the last 2 years? yes / no

If YES, for what reason? _____

Do you frequently, or currently see any other healthcare practitioners?

If YES, who? _____

List any injuries that have stopped you from running/training for > 2 weeks:

Year	Injury	Solutions that helped

Part 3: Desired Outcomes

What goals do you hope to achieve through this running evaluation and treatment?