Bodies in Balance Physical Therapy
Running Analysis

Patient Name: _____ Date of Birth: _____ Age: _____

Email address: _____

General Information:

How did you hear about us? _____

Occupation: _____

What do you hope to gain from this assessment (Goals)?

_____

_____

Have you had a gait analysis before? _____

Runner's History

Do you currently have pain? _____

Please list any injuries/surgeries that you've had in the past 3 years:

_____

_____

_____

Besides running, what physical activities do you currently participate in?

_____

_____

Please describe your typical weekly training/activity routine (type, duration, intensity, terrain, etc.):

Monday: _____

Tuesday: _____

Wednesday: _____

Thursday: _____

Friday: _____

Saturday: _____

Sunday: _____

Estimated average weekly walking and/or running mileage: _____

Please describe your level of competition: Recreational Provincial National International

What footwear do you train in? _____

How many miles have you currently ran in these shoes? _____

What other equipment do you run with? _____.

Patient Name: _____ Date of Birth: _____

Height: _____ Weight: _____ BMI: _____ (therapist will calculate)

Please Circle

Allergies	Yes / No	Dizzy Spells	Yes / No	MRSA	Yes / No
Anemia	Yes / No	Emphysema/Bronchitis	Yes / No	Multiple Sclerosis	Yes / No
Anxiety	Yes / No	Fibromyalgia	Yes / No	Muscular Disease	Yes / No
Arthritis	Yes / No	Fractures	Yes / No	Osteoporosis	Yes / No
Asthma	Yes / No	Gallbladder Problems	Yes / No	Parkinson's	Yes / No
Autoimmune Disease	Yes / No	Headaches	Yes / No	Rheumatoid Arthritis	Yes / No
Cancer	Yes / No	Hearing Impairment	Yes / No	Seizures	Yes / No
Cardiac Conditions	Yes / No	Hepatitis	Yes / No	Smoking	Yes / No
Cardiac Pacemaker	Yes / No	High Cholesterol	Yes / No	Speech Problems	Yes / No
Chemical Dependency	Yes / No	High/Low Blood Pressure	Yes / No	Strokes	Yes / No
Circulation Problems	Yes / No	HIV/AIDS	Yes / No	Thyroid Disease	Yes / No
Currently Pregnant	Yes / No	Incontinence	Yes / No	Tuberculosis	Yes / No
Depression	Yes / No	Kidney Problems	Yes / No	Vision Problems	Yes / No
Diabetes	Yes / No	Metal Implants	Yes / No	Glaucoma	Yes / No

If "Yes" to any of the above, please explain and give approximate dates / describe any other conditions

_____

_____

_____

Fall Risk Assessment:

- Injury because of a fall in the past year? **Yes / No**
- Two or more fall in the last year? **Yes / No**
- Do you feel that you are not walking as well as you were 6 months ago? **Yes / No**
- Do you feel dizzy or have feelings that the room is spinning? **Yes / No**

Surgical History	**Dates**

Current Medications	**Reasons for taking**	**Dosage**

Patient Name: _____ Date of Birth: _____

Pain: It is necessary to determine if you are experiencing any pain, as well as the type and location of the pain.

Do you have pain? Yes / No (If not skip this section)

If yes, please rate your pain during the last 2 weeks by circling a number

No Pain 1 2 3 4 5 6 7 8 9 10 **Unbearable**

What activities make your pain worse? _____

_____

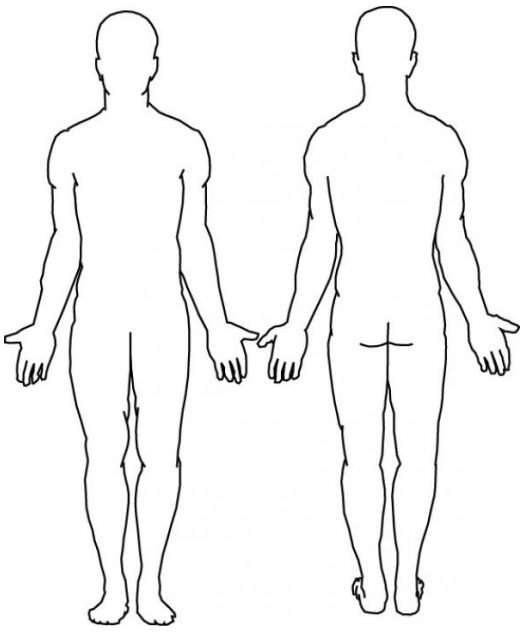
What helps ease your pain? _____

_____

Please select what **best** describes your pain: The pain is…

Constant **Comes and Goes** **Sharp**

Dull **Aching** **Unyielding**



Description of Pain:

_____

_____

_____

_____

_____

_____

_____

Please mark the exact location(s) of your pain on the body diagram above.

Do you have any cultural / religious beliefs that would affect your care? **Yes / No**

Are you receiving ANY Home Health Care of Hospice services? Yes / No

_____ Date: _____

Patient Signature: