

Name: _____ Phone No. _____ Date: _____

HISTORY

Why do you want your running technique to be evaluated?

If you think you are having problems, how would you describe those problems?

How often do you run? _____

How far do you typically run at one time? _____

How far do you run over the course of a week? _____

Do you run: Alone With Someone Else With Group

What kind of terrain do you run on? Asphalt/Street Gravel/Trail Dirt Track Hills Flat Treadmill
 Other: _____

Do you run in any races? Yes No

If so, what type(s) do you participate in (check all that apply)?

Walk Only

5K

10K

Half Marathon

Marathon

Biathlon (Bike and Run)

Triathlon (Swim, Bike, and Run)

Other: _____

Other: _____

Other: _____

TYPES OF SHOES

List below the shoes you run in:

When do you use these shoes?

Short Distance Long Distance Other: _____
 Short Distance Long Distance Other: _____
 Short Distance Long Distance Other: _____
 Short Distance Long Distance Other: _____

What is your goal(s) of having your running evaluated?

Reduced pain

Faster times

Ability to run for longer distances

Other _____

Other _____

Other _____

Anything else you want your physical therapist to know? _____

Instructions: Fill out and fax to **913-768-8118** if you're scheduled at The Rehab Place at Santa Fe Commons
fax to **913-768-1584** if you're scheduled at The Rehab Place in the Southpark Medical Plaza



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RUNNING SMART INTAKE QUESTIONNAIRE

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