

THE RUNNING CLINIC

Runner Questionnaire

September 15, 2008

Dr. Adam Spector, Podiatrist
Montgomery Foot and Ankle Assoc.
Ph: 301-949-FOOT(3668)
laspector@comcast.net
www.myfootdocs.com

Mike Broderick, Coach
Ph: 301-921-1086
MikeBroderick@comcast.net

Rachel Miller, Physical Therapist
ProAction Physical Therapy
Ph: 301-881-CARE(2273)
RachelMillerPT@hotmail.com
www.proactionpt.com

Name: _____ DOB: _____
Address: _____
City: _____ State: _____ Zip: _____
Occupation: _____ Height: _____ Weight: _____
Medical History (ex. Diabetes, asthma, cardiac problems, arthritis, etc.):

Surgeries: _____
Medications: _____

Any concerns/injuries/pain?

Concerns/Pain _____ Exact location _____
Onset/Duration _____ Aggravated by _____
Treatment (meds, rest, physician, physical therapy, podiatrist, etc.):

Getting worse/better _____

Running History: Years running: _____
Avg. miles/week for past 2 months: _____
Longest run in past month: _____
Speed work: yes/no _____
Cross training/Weight training? _____
Avg. number of consecutive days run in past month: _____

Previous best times ever (incl. month/year): 5K _____
10K _____
1/2 / full marathon _____
Prescription orthotics worn? yes/no For how long? _____

Your Goals: Short term: _____ Long term: _____

What would you like to learn from the experts?

Racing strategy _____ Cross training/Weight training _____ running shoes _____
Injury Prevention _____ Efficient running form _____
Other _____