Gateau Physical Therapy & Sports Medicine
"Professional Treatment with Personal Care"

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CLIENT HISTORY AND RUNNING LOG

NAME: ____________________ **AGE:**______ **HEIGHT:**______**WEIGHT:**______ **DATE:**______________

GENDER: ❑ **MALE** ❑ **FEMALE** **MAY WE FOLLOW UP WITH YOU BY PHONE?** ❑ **YES** ❑ **NO**

PHONE: ____________________

BACKGROUND

WHAT IS THE PROBLEM?: ____________________

WHEN DID THE PROBLEM START?: ____________________

HOW DID THE PROBLEM START?: ____________________

DO YOU HAVE PAIN WHILE RUNNING? ❑ YES ❑ NO IF YES, DOES IT INCREASE? ❑ YES ❑ NO

DO YOU HAVE PAIN AFTER RUNNING? ❑ YES ❑ NO IF YES, HOW LONG DOES IT LAST? ____________

WHAT MAKES THE PAIN BETTER? ❑ REST ❑ STRETCHING ❑MEDS ❑ HEAT/COLD ❑ OTHER

PAST INJURIES:

	RIGHT	LEFT	RUNNING RELATED
SHIN SPLINTS	❑	❑	❑
STRESS FRACTURE	❑	❑	❑
ACHILLES TENDONITIS	❑	❑	❑
PLANTAR FASCIITIS	❑	❑	❑
ILIOTIBIAL BAND SYNDROME	❑	❑	❑
KNEE PAIN	❑	❑	❑
COMPARTMENT SYNDROME	❑	❑	❑

	RIGHT	LEFT	RUNNING RELATED
MUSCLE INJURY	❑	❑	❑
LIGAMENT INJURY	❑	❑	❑
DISLOCATION	❑	❑	❑
TENDONTITIS/BURSITIS	❑	❑	❑
FRACTURE	❑	❑	❑
LOW BACK PAIN	❑	❑	❑
OTHER	❑	❑	❑

List all prescription, over-the-counter medications and nutritional/herbal supplements you are taking.

Medication	Dosage	Frequency	Route (oral, injection, etc)

DO YOU SMOKE? ❑ YES ❑ NO

DRINK CAFFEINE? ❑ YES ❑ NO

DRINK ALCOHOL? ❑ YES ❑ NO

List all surgical procedures and other medical problems you have had: ____________________

RUNNING GOALS:

❑ CONTINUE RUNNING AT CURRENT LEVEL ❑ INCREASE RUNNING TO HIGHER LEVEL
❑ COMPETE IN A PARTICULAR RACE ______________________________ ❑ OTHER _____________________________

TRAINING LOG:

YEARS RUNNING __________
CLASSIFY YOUR LEVEL OF RUNNING ❑ RECREATIONAL ❑ COMPETATIVE

VOLUME ________ MILES/WEEK ________ DAYS/WEEK ________ MONTHS/YEAR PACE ________ MIN/MILE

SPEED WORK ❑ YES ❑ NO HILLS ❑ YES ❑ NO
WARM -UP ❑ YES ❑ NO COOL-DOWN ❑ YES ❑ NO
STRETCHING ❑ BEFORE RUN ❑ DURING RUN ❑ AFTER RUN ❑ THROUGHOUT DAY

TYPICAL RUNNING DISTANCE ❑ 5k ❑ 8k ❑ 10k ❑ OTHER
❑ 1/2 MARATHON ❑ MARATHON
TRIATHALON ❑ SPRINT ❑ 1/2 IRONMAN ❑ OLYMPIC ❑ IRONMAN

ADDITIONAL FACTORS:

SHOE AGE:_______MONTHS SHOE BRAND/MODEL: ________________________
ARE YOUR SHOES COMFORTABLE? ❑ YES ❑ NO HEEL LIFT: RIGHT ❑ LEFT ❑ NONE ❑

ORTHOTICS: ❑ YES ❑ NO IF YES: ❑ CUSTOM ❑ OVER THE COUNTER

WATER/SPORTS DRINK USE: ❑ BEFORE RUN ❑ DURING RUN ❑ AFTER RUN HOW MUCH?_____________________

ARE YOU USING SUPPLEMENTS/GELS? ❑ YES ❑ NO
IF YES WHAT TYPE AND HOW MUCH____

WOULD YOU LIKE TO CONSULT A NUTRITIONIST? ❑ YES ❑ NO