



FISHER | TITUS

Subjective Intake Form

Name: _____

Date: _____

Age: _____

Gender: _____

Diagnosis: _____

Referring Physician: _____

Current Complaint / Mechanism of Injury:

Pain at Best: _____

Description of Pain: _____

Pain at Worst: _____

Previous Injuries and Treatment:

Allergies: _____

Medications: _____

Menstrual Cycle (if applicable): _____

Average Hours Sleep/Night: _____

Training History

Miles/Week (Acute): _____

Average Miles/Week (over last 6 weeks): _____

Long Run/Week (Acute): _____

Average Long Run/Week (over last 6 weeks): _____

Runs/Week : _____

Training Surface(s): _____

Mile Pace: _____

Tempo Run Pace: _____

Long Run Pace: _____

Style / Brand of Running Shoe: _____

Shoe Choice Reason: _____

Orthotic Use: _____

Cross Training (Type/Frequency):

Strength Training (Type/Frequency):

Running Goals:



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RUNNER'S EVALUATION FORM

Training History

Level of Competition:

- ☐ Recreational only
- ☐ Recreational competitive
- ☐ Competitive (HS/college)
- ☐ Elite

Running Surface:

- ☐ Treadmill
- ☐ Street (asphalt)
- ☐ Sidewalk (concrete)
- ☐ Trail
- ☐ Track

Cross-Training:

- ☐ Biking
- ☐ Swimming
- ☐ Weights
- ☐ Stairs
- ☐ Yoga/Stretching
- ☐ Other: _____

Years of running: _____

Long run: _____

Running Club: _____

Runs/week: _____

Pace/mile: _____

Shoe type: _____

Mileage/week: _____

Miles on shoe: _____

Shoe inserts or Orthotics: ☐ Yes ☐ No

Are you in training? ☐ Yes ☐ No

Race and Date: _____

Recent change in your training?

- ☐ Increased mileage
- ☐ New shoes or inserts
- ☐ Speed work or track work
- ☐ Hill training
- ☐ Change in terrain

When you run, when do symptoms occur?

- ☐ Every step of the run
- ☐ Worse toward the end of the run
- ☐ Worse at the start & then improves
- ☐ Only after the run ends (next day)

Medical History

Date and Description of Injury: _____

Previous Treatments for Injury: _____

Past Medical & Surgical History: _____

Medications: _____

Allergies: _____

Prior Musculoskeletal Injuries: _____

History of stress fractures: ☐ Yes ☐ No

steroid use: ☐ Yes ☐ No

osteoporosis: ☐ Yes ☐ No

eating disorders: ☐ Yes ☐ No

Female History: ☐ N/A

reg. periods: ☐ Yes ☐ No

pregnant: ☐ Yes ☐ No

age of 1st period: _____

date of last period: _____