



BOWEN
Physical Therapy Services Inc.

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Runner's Questionnaire

Surname		Given	
Address: Street			
City	Province		Postal code
Telephone Number	Home	Work	Cell
Email Address			
Date of Birth	dd	mm	yyyy
Driving permit number			

Running History

Number of years of running			km/Week (avg, last three years)		
Speciality	5k	10k	half	full	triathlete
Other Events					
Personal Bests					
Any recent changes in: (please circle any that apply)					
Distance	Intensity	Surface	Hills	Running Shoes	Fatigue stress

Health Questions	Yes	No	Details
Are you taking any drugs (prescribed or not), supplements?			
Do you have a family history of sudden death before the age of 50?			
Have you ever lost consciousness, felt dizzy, felt chest pain or palpitations during physical activity?			
Do you have trouble breathing? Do you cough during physical activity?			
Have you ever suffered from dehydration, heat stroke or muscle cramping?			
Do you have a chronic medical condition or a disease that requires regular medical care?			
Do you have concerns about your weight or your diet?			
Do you have concerns about your menstrual cycle? (irregular, absent, abundant)? Females only please.			
Do you wear orthotics? If yes, how long?			
Have you had any running injuries now or in the past? If yes, please list them			

Signature _____

Date _____