

Gait Analysis Client Information

Background Information

Name: _____

Date of Birth: _____

Height: _____ cm

Weight: _____ kg

Foot Dominance (check one)

Right Left

Gender (check one)

Male Female

List current physical activity

What year did you start running? _____

Level (check one)

Competitive Recreational

**If competitive, please complete the following questions. If recreational, move on to injury questions.*

What is your typical running distance?

_____ casual runner (no races)

_____ 5k

_____ 10k

_____ half marathon

_____ full marathon

_____ other distance

Personal best time (if you know)

HH: _____ MM: _____ SS: _____ What year? _____

How many races do you compete in per year? _____

Injury Profile

Injury definition (choose one)

no injury

training volume/intensity affected

2 workouts missed in a row

continuing to train in pain

Who diagnosed your injury?

- | | |
|--|---|
| <input type="checkbox"/> doctor | <input type="checkbox"/> physiotherapist |
| <input type="checkbox"/> chiropractor | <input type="checkbox"/> athletic therapist |
| <input type="checkbox"/> massage therapist | <input type="checkbox"/> coach |
| <input type="checkbox"/> self | <input type="checkbox"/> not diagnosed |

Primary injury

Location:

- | | |
|---|---|
| <input type="checkbox"/> lumbar spine | <input type="checkbox"/> sacroiliac joint |
| <input type="checkbox"/> hip/pelvis | <input type="checkbox"/> thigh |
| <input type="checkbox"/> knee | <input type="checkbox"/> lower leg |
| <input type="checkbox"/> ankle | <input type="checkbox"/> foot |
| <input type="checkbox"/> other (please specify) _____ | |

Which leg are you experiencing the primary injury? (check one)

- Right Left Bilateral

Duration of primary injury? _____

Other information about primary injury

Secondary injury

Location:

- | | |
|---|---|
| <input type="checkbox"/> lumbar spine | <input type="checkbox"/> sacroiliac joint |
| <input type="checkbox"/> hip/pelvis | <input type="checkbox"/> thigh |
| <input type="checkbox"/> knee | <input type="checkbox"/> lower leg |
| <input type="checkbox"/> ankle | <input type="checkbox"/> foot |
| <input type="checkbox"/> other (please specify) _____ | |

Which leg are you experiencing the secondary injury? (check one)

- Right Left Bilateral

Duration of secondary injury? _____

Other information about secondary injury