

**PARA ENDURANCE ATHLETE
INJURY QUESTIONNAIRE**

Name: _____

Today's date: _____

Injury History

What is the primary location of your musculoskeletal pain? _____

Which side is affected? Right Left Both

When did the pain begin? (days/weeks/months ago) _____

How did the pain begin? (e.g., trip and fall, gradually while training) _____

Rate your pain from 0-10 (0 = no pain, 10 = extreme pain):

Right now: _____ At worst: _____

To what extent have you modified your training due to the pain?

- No modification
- To a minor extent
- To a moderate extent
- To a major extent

Circle any additional symptoms that you have:

Swelling Stiffness Weakness Instability Popping Numbness

What makes your pain worse? _____

What makes your pain better? _____

Do you think that the adaptive equipment contributed to the pain?

- Yes No Not applicable

If yes, describe: _____

Did you change or modify your adaptive equipment in the 4 weeks before experiencing the pain?

- Yes No

Have you experienced a similar injury in the past?

- No Yes If yes, describe: _____

Have you had other injuries to this body part in the past?

- No Yes If yes, describe: _____

Have you ever had a bone stress injury (stress fracture or stress reaction)?

No Yes If yes, how many? _____

What medical services (if any) have you received for the musculoskeletal pain?

- | | |
|---|--|
| <input type="checkbox"/> Acupuncture | <input type="checkbox"/> Over-the-counter medication |
| <input type="checkbox"/> Brace | <input type="checkbox"/> Physical therapy |
| <input type="checkbox"/> Chiropractic care | <input type="checkbox"/> Physician evaluation |
| <input type="checkbox"/> CT scan | <input type="checkbox"/> Podiatrist evaluation |
| <input type="checkbox"/> Injection | <input type="checkbox"/> Prescription medication |
| <input type="checkbox"/> Massage therapy | <input type="checkbox"/> Shockwave therapy |
| <input type="checkbox"/> MRI | <input type="checkbox"/> Ultrasound |
| <input type="checkbox"/> Occupational therapy | <input type="checkbox"/> X-ray |
| <input type="checkbox"/> Orthotics | <input type="checkbox"/> Other _____ |

Training History

Do you currently participate in any of the following para athlete programs?

- Duo Team (runner pushing an individual with a physical disability in a chair)
- Guide/Support Runner
- Handcycle Running Program
- Para Athletics Division
- Wheelchair Division
- Other _____
- None of the above

What is your para/adaptive sport impairment(s)?

- | | |
|--|--|
| <input type="checkbox"/> Vision – low vision | <input type="checkbox"/> Physical – limb deficiency |
| <input type="checkbox"/> Vision – blind | <input type="checkbox"/> Physical – short stature |
| <input type="checkbox"/> Physical – brain disorder | <input type="checkbox"/> Physical – leg length difference |
| <input type="checkbox"/> Physical – cerebral palsy | <input type="checkbox"/> Physical – impaired passive range of motion |
| <input type="checkbox"/> Physical – spinal cord-related disorder | <input type="checkbox"/> Physical – other _____ |
| <input type="checkbox"/> Physical – neuromuscular disorders | <input type="checkbox"/> Intellectual impairment |

If known, what is your para-athletics classification, e.g., T54? _____

Please answer the following questions about your training before the current injury:

What was the average number of days per week that you trained? _____ days

What was the average weekly number of hours that you trained? _____ hours

What was the duration of a typical long training session? _____ hours

In the past 12 months, what additional exercises did you do at least once per week on average?

- | | |
|---|---|
| <input type="checkbox"/> Arm cycle | <input type="checkbox"/> High-intensity interval training |
| <input type="checkbox"/> Cycling/spinning | <input type="checkbox"/> Rowing |
| <input type="checkbox"/> Elliptical machine | <input type="checkbox"/> Swimming |
| <input type="checkbox"/> Heavy resistance training | <input type="checkbox"/> Yoga/Pilates |
| <input type="checkbox"/> High repetition, low resistance training | |

Endurance Race History

In which of the following races have you participated?

- | | |
|--|---|
| <input type="checkbox"/> 5K | <input type="checkbox"/> Marathon |
| <input type="checkbox"/> 10K | <input type="checkbox"/> Ultramarathon |
| <input type="checkbox"/> Half marathon | <input type="checkbox"/> Other distance _____ |

Are you currently training for an endurance race?

- Yes No

If "Yes" please complete the following questions about the upcoming race:

What is the date of the race? _____

What is the distance of the race? _____

How will you be participating in the race?

- Handcycle
- Push rim wheelchair
- Racing wheelchair
- Running, walking, or a combination of running and walking
- Other _____

What adaptive equipment will you use for participating in the race?

- Crutches
- Manual wheelchair
- None
- Prosthesis - lower limb
- Prosthesis - upper limb
- Stick/cane
- Walking frame
- Other _____

How many races of this distance have you completed? _____

What is your primary goal for the race? _____

What is your goal finishing time for the race? _____

Do you plan to follow a specific training plan for the race?

- No Yes, describe: _____

Health History

In the past 4 weeks, how rested have you felt on average upon waking in the morning?

- Completely rested Somewhat not rested
 Somewhat rested Not rested at all

In the past 4 weeks, how many days per week on average are your daytime activities or training affected by inadequate sleep? _____ days

Have you ever experienced or been diagnosed with any of the following?

- Anemia Low testosterone
 Broken bone Low vitamin D
 Eating disorder Pelvic floor dysfunction
 Low bone mineral density Polycystic ovary syndrome
 Low estradiol Thyroid disease or disorder
 Low iron or ferritin Urinary incontinence

Have you lost more than 5% of your body weight in the past 3 months?

- Yes No

Do you regularly restrict any of the following food groups from your diet?

- All animal products (vegan) Only red meat
 All meats (vegetarian) Dairy products
 Land-based meats (pescatarian) Carbohydrates
 Other _____

Which of the following supplements (if any) do you regularly take?

- Calcium Multivitamin
 Vitamin D Other _____
 Iron

Female and Transgender Male Health History

Have you ever had a menstrual cycle?

- Yes No

If "Yes" please complete the following questions:

At what age did you get your first menstrual cycle? _____ years old

Which of the following best describes your current menstrual cycle?

- I get my cycle every 21-35 days
- My cycles are separated by more than 35 days but come at regular intervals (e.g., every 45 days)
- My cycles are very irregular with no typical pattern, but I have had 3 or more cycles in the past year
- I do not currently menstruate or have had less than 3 cycles in the past year
- None of the above

Are you currently using birth control?

- No Yes, describe: _____

Are you currently pregnant?

- Yes No Don't know

Have you given birth in the past 12 months?

- Yes No

If "Yes", are you breastfeeding?

- Yes No