RUNNER HEALTH CONSORTIUM

AMSSM COLLABORATIVE RESEARCH NETWORK

RUNNER 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 running) ________________
____

Rate your pain from 0-10 (0 = no pain, 10 = extreme pain):
Right now: _______ At worst: ________

To what extent have you modified your running 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? ______________________________________

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?

- ☐ Acupuncture
- ☐ Brace
- ☐ Chiropractic care
- ☐ CT scan
- ☐ Injection
- ☐ Massage therapy
- ☐ MRI
- ☐ Occupational therapy
- ☐ Orthotics
- ☐ Over-the-counter medication
- ☐ Physical therapy
- ☐ Physician evaluation
- ☐ Podiatrist evaluation
- ☐ Prescription medication
- ☐ Shockwave therapy
- ☐ Ultrasound
- ☐ X-ray
- ☐ Other ___________________________

Running History

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

What was the average number of days per week that you ran? ______ days

What was the average weekly distance that you ran? ______ miles

What was the distance of a typical long run? ______ miles

What type(s) of running shoes do you regularly use?

- ☐ Maximal
- ☐ Minimal
- ☐ Motion control/stability
- ☐ Neutral
- ☐ Racing flats
- ☐ Trail shoes
- ☐ Don't know
- ☐ Other ___________________________

Do you regularly use a running shoe with a carbon fiber plate (“super shoe”)?

☐ Yes ☐ No

Do you use orthotics or inserts in your running shoes?

☐ Yes ☐ No

Did you recently begin using a new running shoe?

☐ Yes ☐ No

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

- ☐ Arm cycle
- ☐ Cycling/spinning
- ☐ Elliptical machine
- ☐ Heavy resistance training
- ☐ High repetition, low resistance training
- ☐ High-intensity interval training
- ☐ Rowing
- ☐ Swimming
- ☐ Yoga/Pilates

Endurance Race History

In which of the following races have you participated?

- ☐ 5K
- ☐ 10K
- ☐ Half marathon
- ☐ Marathon
- ☐ Ultramarathon
- ☐ 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 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 rested
- ☐ Somewhat not 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
- ☐ Broken bone
- ☐ Eating disorder
- ☐ Low bone mineral density
- ☐ Low estradiol
- ☐ Low iron or ferritin
- ☐ Low testosterone
- ☐ Low vitamin D
- ☐ Pelvic floor dysfunction
- ☐ Polycystic ovary syndrome
- ☐ Thyroid disease or disorder
- ☐ 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)
- ☐ All meats (vegetarian)
- ☐ Land-based meats (pescatarian)
- ☐ Only red meat
- ☐ Dairy products
- ☐ Carbohydrates
- ☐ Other ____________________

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

- ☐ Calcium
- ☐ Vitamin D
- ☐ Iron
- ☐ Multivitamin
- ☐ Other ____________________

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