Assigned Study Number: ________________

Data Collection Form
Station I- Health Information Survey

Participant Name: ____ Date: ____________

Contact information: Email: ____

Phone: ____

Pertinent Medical History:

Date of Birth: ________________________________ **Sex:** Male Female

Height: _____________________________________ Weight: _________________

Are you? Right Handed Left Handed Both/Ambidextrous

What is your activity level? Please indicate below:

If sports, how often/duration? ____

Sedentary, no regular exercise Running Biking

Stretching/Yoga Soccer Swimming

Other: ____

____

Have you had any of the following injuries or illness? Please circle all that apply.

Cancer	Diabetes	Joint Pain	Fracture/broken bones
Seizures	Joint Sprains	Muscle Strains	Surgery
Asthma	Muscle tightness	Back Pain	**Abdominal Mesh**

Explain circled answers above: ____

Are you currently pregnant? Yes No

Are you currently menstruating? **Yes** **No**

Do you have a history of hamstring tightness? Yes No

What is your perception of your hamstring tightness? (Circle one number below)

0 1 2 3 4 5 6 7 8 9 10

None Mild Moderate Severe

Assigned Study Number: ________________
Evaluator Initials: _____

Station 2: Data Collection (For Clinical Use Only)

Depth of abdomen/depth @ level of umbilicus (cm): ___________________________________

SLR Goniometry: Right: _______________ Left: ____________________

Psoas Palpation Depth (cm): Right: _______________ Left: ____________________
1” lateral to the umbilicus

SLR Goniometry/Psoas: Right: _______________ Left: ____________________