



1 Personal Athlete Information

Athlete Identification Number: _____

Nationality: _____

Age: _____

Gender: Female Male

Years of Practicing With Archery: _____

Height: _____ Weight: _____

Hand you write? Right Left

Hand you pull the cord; Right Left

2 Training/Bow

- How many libres weight the bow you use? _____
- What type of bow do you use? Recurve Compound
- How many days did you train in the most recent (In the last) season? _____
- How long (in minutes) did each training session last in the most recent season?
- On average, how many arrows do you shoot in each practice? _____
- How many matches have you competed in this most recent season? _____
- On average, how long (in minutes) does each match last? _____
- Which of the below are part of your training routine?

Upper Body Strength training	Yes <input type="checkbox"/>
Lower Body Strength training	Yes <input type="checkbox"/>
Right arm strength training	Yes <input type="checkbox"/>
Left arm strength training	Yes <input type="checkbox"/>
Aerobic conditioning	Yes <input type="checkbox"/>
Stretches at the beginning of training	Yes <input type="checkbox"/>

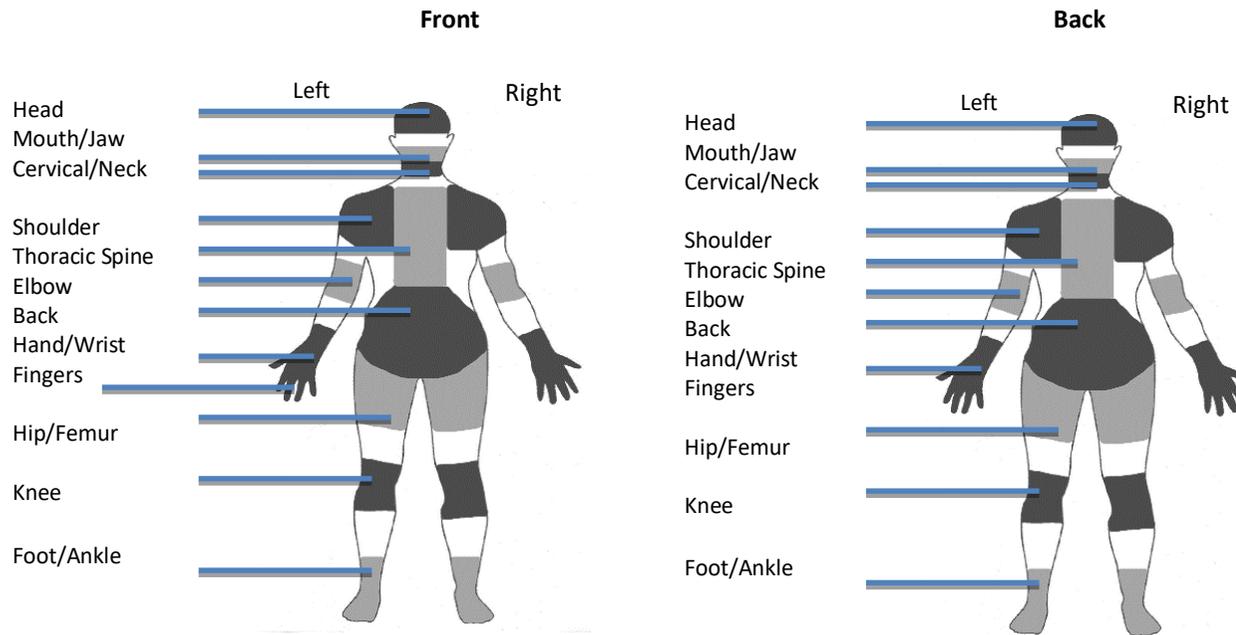
Stretches at the end of training	Yes <input type="checkbox"/>
Relaxation techniques	Yes <input type="checkbox"/>
Concentration techniques	Yes <input type="checkbox"/>
Breathing exercises	Yes <input type="checkbox"/>
Other	

- Do you warm up before each training session? Yes No
- If so, how many minutes? _____
- Do you perform a cooldown after each training session? Yes No
- If so, how many minutes? _____
- During the year, do you undergo physical evaluation (join range of motion, muscular strength)? Yes No
- Do you have a specific nutritional plan; Yes No

3. Training related pain

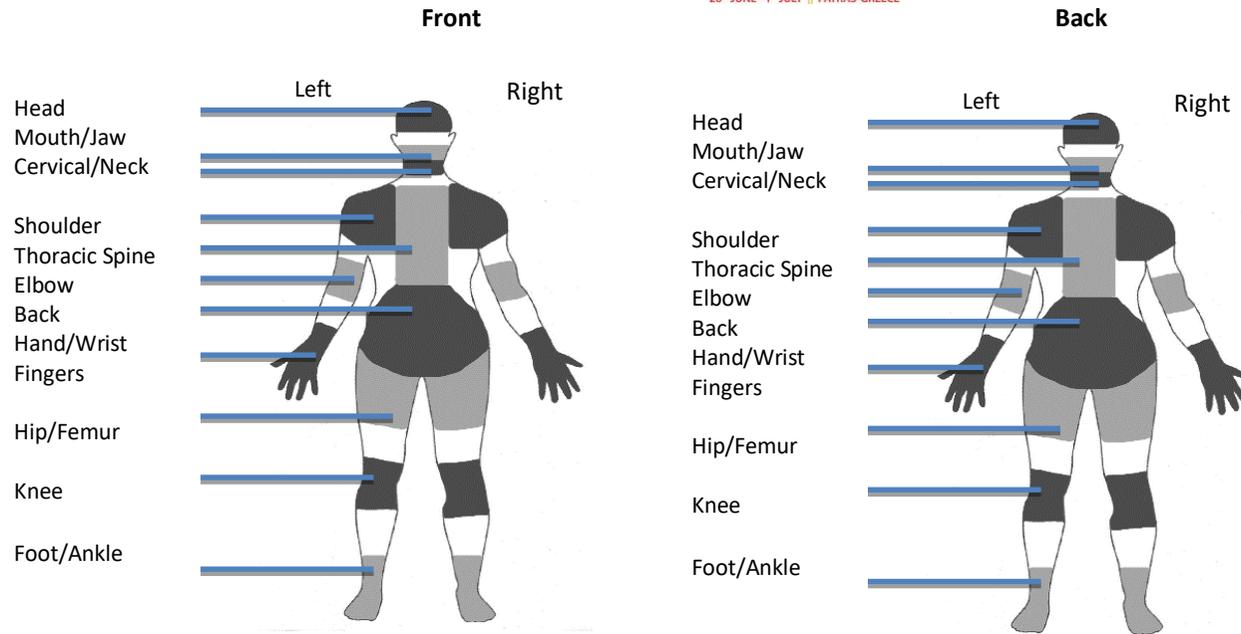
- Do you experience any persistent pain for a long period of time that is due to training? Yes No
- If you have a pain or discomfort during training, do you tell to your coach? Yes No
- If you have a pain, do you take any medication for it so you can train? Yes No
- Do you take any medication regularly?

- Does the medication you take help with the pain or discomfort? None , Slight , Some , Much , Very Much
- If you experience any chronic pain during training, fill in the chart below (one chart for each site of pain)



Pain number...

Did an injury occur?	How long ago did the pain start? (days/month)	Pain duration; (days/months)	Type of pain (Numbness, sharp, burning sensation, dull, pinching, other)	Usual pain intensity; (0= no pain, 10 = extreme pain)	Diagnosis; (ex; tendinitis, back pain, rotator cuff, etc.)	Did you have to stop training;	For how long were you unable to train? (days)	Did you have physical therapy?	How many sessions? (number)	Was any improvement ?
Yes <input type="checkbox"/> No <input type="checkbox"/>				/10		Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>		None <input type="checkbox"/> Slight <input type="checkbox"/> Some <input type="checkbox"/> A lot of <input type="checkbox"/> Very Much <input type="checkbox"/>

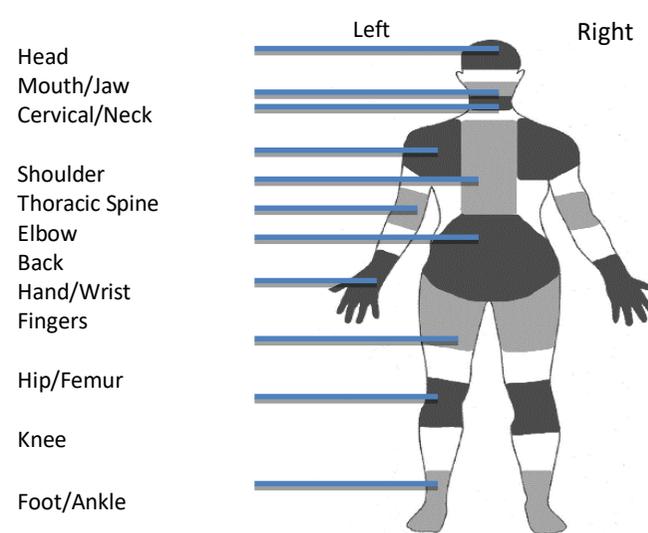
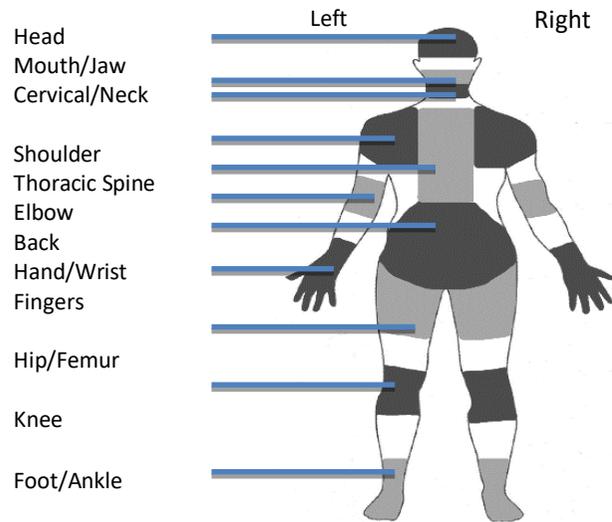


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Yes <input type="checkbox"/> No <input type="checkbox"/>				/10		Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>		None <input type="checkbox"/> Slight <input type="checkbox"/> Some <input type="checkbox"/> A lot of <input type="checkbox"/> Very Much <input type="checkbox"/>

Front

Back



Pain number...

Did an injury occur?	How long ago did the pain start? (days/month)	Pain duration; (days/months)	Type of pain (Numbness, sharp, burning sensation, dull, pinching, other)	Usual pain intensity; (0= no pain, 10 = extreme pain)	Diagnosis; (ex; tendinitis, back pain, rotator cuff, etc.)	Did you have to stop training;	For how long were you unable to train? (days)	Did you have physical therapy?	How many sessions? (number)	Was any improvement ?
Yes <input type="checkbox"/> No <input type="checkbox"/>				/10		Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>		None <input type="checkbox"/> Slight <input type="checkbox"/> Some <input type="checkbox"/> A lot of <input type="checkbox"/> Very Much <input type="checkbox"/>

7. Please circle the appropriate answer which accurately describes your physical condition **during the last week**

	No difficulty	Mild difficulty	Moderate difficulty	Severe difficulty	Unable
Did you have any difficulty using your usual technique with your bow?	1	2	3	4	5
Did you have any difficulty training due to any pain?	1	2	3	4	5
Did you experience any difficulty shooting in training as well as you would like?	1	2	3	4	5
Did you have any difficulty spending your usual amount of time training?	1	2	3	4	5

4. General Health Status

1. Have you had any medical procedures performed in the past? (ex, surgery)

2. Do you have any other general medical conditions? (ex, high blood pressure, diabetes, thyroidism, etc.)

This is the last question. Thank you for your cooperation!