**Flexibility Assessment and Questionnaire**

Use this document to record your values from the Flexibility Questionnaire chapter of Moving Stretch: Work Your Fascia to Free Your Body.

Do these tests right before you begin your new stretching regime, and continue at regular intervals (once a week or once a month, for example) so that you can keep track of your progress. If you decide to keep a stretching journal you can keep the results with that.

It may be worth creating a separate folder to keep your photos in and I would save each with the date and position as their file name, i.e. 7/9/17-front, 7/9/17-side, for quick reference.

**Flexibility Self-Tests**

|  |  |  |
| --- | --- | --- |
| **Test**  **(and Area Being Measured)** | **Distance** | **Notes** |
| Touching Toes  (Hamstrings) |  |  |
| Sideways Straight leg Raise    (Abductor and Adductors) | Left:  Right: |  |
| Knee to Chest    (Hip Flexors) | Left:  Right: |  |
| Trunk Twist    (Torso and Shoulders) | Left:  Right: |  |
| Elbow Pull Back  (Chest) | Left:  Right: |  |
| Back Scratch  (Arms and Shoulders) | Left arm on top:  Right arm on top: |  |

**Health and Flexibility Questions**

|  |  |  |
| --- | --- | --- |
| Today’s date: | | |
| **Question** | **Answer** | **More Info** |
| How would you rate your general health out of 10 (10 being the best, i.e. 6/10)? |  |  |
| How would you rate your general flexibility 1-10? |  |  |
| Does inflexibility currently limit you in any way, i.e. movement, exercise, performance or other? If so please score each issue out of 10 (10 being the most problematic and 0 no issue at all) |  |  |
| Do you have any main health/ physical issues you hope the stretching will help? If so please rate the severity of the issue or pain level out of 10 (10 is the worst pain possible and 0 is no pain at all). |  |  |

**Mood and Energy Questions**

|  |  |  |
| --- | --- | --- |
| Today’s date: | | |
| **Question** | **Answer** | **More Info** |
| Please rate your mood on a general day-to-day basis out of 10. |  |  |
| Please rate your energy levels on a day-to-day basis out of 10. |  |  |
| Please rate your sleep out of 10. For example, think about whether you get to sleep easily, your sleep is undisturbed, whether you wake up refreshed etc. |  |  |
| Please rate your appetite out of 10 (10 is a higher level of appetite). |  |  |

**Stretching Diary**

The table below can help you keep track of your stretching and over time will help you to see both improvements and recurring issues that need to be addressed.

**Date:**

|  |  |  |  |
| --- | --- | --- | --- |
| **Stretch** | **Reps** | **Notes (including range or motion, ease of movement, any modifications needed etc)** | **Quality of Stretch /10** |
|  |  |  |  |