AposHealth

Patient ID: _____

Date: _____ Patient name: _____

Rate your ability to do the activities in the last week by circling the appropriate number.

0 = No issue - 10 = Cannot perform activity

	No issue										Cannot perform
1. Activity:	0	1	2	3	4	5	6	7	8	9	10
2. Activity:	0	1	2	3	4	5	6	7	8	9	10
3. Activity:	0	1	2	3	4	5	6	7	8	9	10

Follow up subjective assessment Q's

1. Do you wear your AposHealth shoes?
   - ☐ Everyday
   - ☐ 5-6 days a week
   - ☐ 3-4 days a week
   - ☐ 1-2 days a week
   - ☐ Not at all

2. How long do you wear your AposHealth shoes for each day (including sitting and time spent up on your feet)?

   - ☐ 30 mins or less
   - ☐ Up to 1 hour
   - ☐ 1-2 hours
   - ☐ 2-3 hours
   - ☐ More than 3 hours

3. When wearing your AposHealth shoes, how much time are you on your feet (standing/walking)? 0% to 100% on your feet?

   _____% standing or walking around with the AposHealth shoes

4. How much time are you on your feet in your AposHealth shoes before sitting:

   - ☐ 1-3 minutes at a time
   - ☐ 5-10 minutes at a time
   - ☐ 10-15 minutes at a time
   - ☐ More than 20 minutes at a time
   - ☐ None

5. How do you wear your AposHealth shoes? (Select all that apply)

- ☐ Like slippers doing normal activities at home
- ☐ In the office/ at work
- ☐ Occasional outdoor usage in the garden
- ☐ Outdoor walking
- ☐ Deliberate walking around my home
- ☐ Pacing up and down a corridor
- ☐ Occasional usage on stairs

6. Do you feel wobbly when using your AposHealth shoes?

- ☐ No
- ☐ Sometimes
- ☐ All the time

7. Compared to when you are barefoot or in normal shoes, how does your pain feel when you are wearing your AposHealth shoes?

- ☐ Better
- ☐ Worse
- ☐ The same

8. During usage or after wearing your AposHealth shoes do you feel any **increased** muscle/joint soreness, or pain?

- ☐ Yes
- ☐ Not sure
- ☐ No

9. Do you have any new areas of pain which you didn't feel before?

- ☐ Yes
- ☐ No

9a) Was there an injury that caused the new pain(s)?

- ☐ Yes
- ☐ No

9b) Have you ever experienced this pain before?

- ☐ Yes
- ☐ No

10. **Focusing on your main area of pain:**

Rate the current level of difficulty associated with each activity, 0 = able to perform at prior level or before injury/problem and 10 = unable to perform/too difficult or painful

☐ **Walking** _____ when walking more than_____

☐ **Going up stairs** _____ after _____

☐ **Going downstairs** ____ after _____

☐ **Standing** _____ after _____

☐ **Sitting** _____ after _____

11. Compared to before you started AposHealth treatment do you feel there has been:

- ☐ An overall improvement (big or small)
- ☐ No change
- ☐ A deterioration

11a) How much better do you feel since starting AposHealth treatment?

Scale 0%-100% (no better to 100% better): _____

AposHealth

Patient ID: _____

Objective Assessment:			
BF NPRS	**/10**	**Severity:**	**Follow up #:**

AposHealth Calibration: Change made: YES/NO

Final Calibration		New Pods	Positional adjustment made and Rationale	HS	Disc
Lt.	Toe:				
	Heel:				
Rt.	Toe:				
	Heel:				

PF/DF/Ipsilateral raise: _____

NPRS after calibration: /10

Unsuccessful Device Calibrations:

Notes for future follow ups:

New Goal(s):

Instructions for progress in treatment:

AposTherapy Treatment Program

General advice/specific exercise program?

Next Follow-up in_____ weeks

Physical Therapist Signature: _____ Date: _____