Name:
Birthdate:

How can Apos begin to improve your life?

Which activities are you unable to do or are having difficulty with as a result of your current problem/diagnosis?

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

(Rate your ability to do the activities in the last week from 0 - 10: 0 = no issue, 10 = cannot perform at all)

☐ **Walking** Rate your ability out of 10: _____ when walking more than_____

☐ **Going up stairs** Rate your ability going up stairs, out of 10: _____ after _____

☐ **Going downstairs** Rate your ability going downstairs, out of 10: ____ after _____

☐ **Standing** Rate your ability when standing, out of 10: _____ after _____

☐ **Sitting** Rate our ability when sitting, out of 10: _____ after _____

☐ **Other:** _____ Rate out of 10: _____ after _____

☐ **Other:** _____ Rate out of 10: _____ after _____

From most significant to least, which area bothers you the most (Back / Hip / Knee / Ankle)?

_____

My pain?

☐ depends on how I cope with pain

☐ may not go away but I am ready to change how I deal with it

☐ will only get better with some surgical procedure or medication

☐ doesn't improve no matter what I have tried

2. **Do any of these reduce your pain?**

☐ Bending forwards ☐ Changing positions/movement ☐ Arching backwards

☐ keeping my knee slightly bent ☐ shoes with a slight heel

☐ Other: _____

3. **Daily pain**:

In the morning my joint(s) feel stiff: ☐ Yes, it takes _____minutes to ease up ☐ No

I wake up because of pain: ☐ Yes, about _____ ☐ No

Name:
Birthdate:

4. What area(s) affects you the *most* with normal activities?
(Check all that apply and circle Left / Right / Both sides / Middle of the back)

- ☐ mostly in the front part of the knee (Left / Right / Both)
- ☐ Inner part of the knee (Left / Right / Both)
- ☐ outer part of the knee (Left / Right / Both)
- ☐ behind the knee/leg (Left / Right / Both)
- ☐ Lower back (Left / Right / Middle)
- ☐ Groin/hip (Left / Right / Both)
- ☐ Ankle (Left / Right / Both)
- ☐ Other:_____

5. What treatments have you had for the pain? (Check all that apply)

☐ None ☐ Physical Therapy ☐ Acupuncture

☐ Steroid Injections (date of last one: ____/____/20____)

☐ Other injections (date of last one: _____/_____/20____)

☐ Other: _____

6. Have you had any other major injuries or surgeries to the low back and/or lower body?

☐ Yes, please describe:_____

☐ No

Have you had a MRI/CT scan/x-ray in the past? ☐ Yes ☐ No

If yes, diagnosis: ☐ Osteoarthritis ☐ Meniscal tear ☐ Other: _____

7. Do you have any other diagnosed conditions?

☐ Thyroid ☐ High Blood Pressure ☐ Heart Conditions ☐ lung conditions

☐ Rheumatoid Arthritis ☐ Epilepsy ☐ Asthma ☐ Diabetes

☐ History of cancer ☐ Osteoporosis (low bone density) ☐ No

☐ Other: _____

Current medication: _____

Subjective hx/Past medical hx: Had symptoms for roughly: _____months / years (circle one)

Name:
Birthdate:

If Velocity is > 80 cm/sec, use clinical judgement to determine if Balance Test required.
If Velocity < 80 cm/sec perform one of Balance Test below:

AposHealth® Balance Test

Single leg stand (≥8 sec pass)

Rt_____ secs Lt_____ secs

Tandem (≥10 sec pass)

Rt_____ secs Lt_____ secs

TUG (Avg. 3 is ≤ 12 seconds):

Velocity in Apos:

Date:					Normal Values
Velocity					≥ 110 cm/sec
L Step Length					≥ 55 cm/sec
R Step Length					
Step Diff.					≤ 1.5 cm
L SLS					38.5% – 40.5%
R SLS					
SLS Diff.					≤ 1.5%

Barefoot walking pain: /10
Location of pain:

Pod Size	Pod Convexity	Primary and secondary pain location Heel Pod Position	Flat/PF/DF
• 85 all around for size < 43 • 95 all around size ≥ 43	**Severe – A** ASF ≤ 35 Velocity ≤ 80 **Moderate – B** ASF 36 - 60 Velocity 81-109 **Mild – C** ASF ≥ 61 Velocity ≥ 110	Knee • 1 line toward soft tissue (patella/tendon, ligaments, muscles) • 1 line away from joint or meniscus Left / Right: A/P: ; M/L:	Start at flat position
		Back/Hip OA • 2 lines posterior Left: ☐ P2 Right: ☐ P2	Start at flat position
		Ankle • 1 line toward soft tissue (tendon, ligaments) • 1 line away from talocrural/subtalar joint Left / Right: A/P: ; M/L:	Start in PF • When lower back is involved – stay in flat

Left	Right

Pain location	Heel or *Toe pod position	Flat/PF/DF
Knee *Step length Rule	Pain when the heel comes down: Heel Pod • Golden Rule: toward soft tissue, away from weight bearing structure	Go into PF as needed • PF for pain anywhere posterior leg • If lower back is involved and prefers DF– stay in flat
Back	Pain at push off: Toe Pod • Try moving posterior first • Golden Rule second	DF or PF depending on positional preference
Hip OA		Go into DF
Ankle *Step Length Rule		• When lower back is involved and prefers DF – stay in flat

☐ Ipsilateral raise > 3% & pain: 1x raise on painful side
☐ *Step length < 50 cm: 1 line posterior Heel

Name:
Birthdate:

Final Calibration: **Device Size:**

○ Lace ○ Velcro	Pods used		Position			Spacers	Rationale
			Shift		Clicks (N-6)		
Left Toe	○ 85 ○ 95	○ A ○ B ○ C	Ant	Post		HS:	
			Med	Lat			
Left Heel	○ 85 ○ 95	○ A ○ B ○ C	Ant	Post		HS:	
			Med	Lat			
Right Toe	○ 85 ○ 95	○ A ○ B ○ C	Ant	Post		HS:	
			Med	Lat			
Right Heel	○ 85 ○ 95	○ A ○ B ○ C	Ant	Post		HS:	
			Med	Lat			
○ Flat ○ Dorsiflexion due to: ○ Plantarflexion due to:						NPRS in device: /10	
○ Ipsilateral raise: ○ L ○ R							

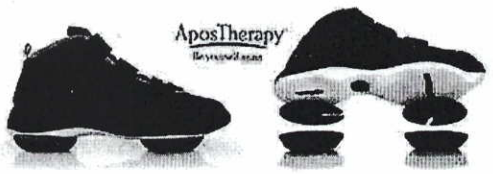
Treatment Program:

Mild: 20 min. of walking + 10 min. walking weekly	Moderate: 10 min. of walking + 5 min. walking weekly	Severe: 5 min of walking + 1-2 min. walking weekly

Signature (ATC)..... Licensed Physical Therapist

Name: ..... Date: .....

ProHealth & Fitness PT OT
www.ProHealthPTOT.com
T: 212.600.4781
F: 800.655.3780



APOS CHECKLIST (inclusion criteria)

DATE: ____/____/____ PATIENT: _____ SOURCE: _____

Pts primary doctor: _____ Specialist Dr. _____

YES **NO**

____ ____ **Knee and/or Back appropriate diagnoses**
- List provided for each knee and/or back _____

____ ____ **Balance and Safety Clearance**
- No significant falls risk for APOS (can pt walk ~20' inside without holding on?)

_____

____ ____ **Moderate or advanced knee/back issues**
- Chronic and persistent, not adequately/satisfactorily/totally controlled with conservative measures (i.e. rest, decreased activity, PT, injections)

_____

____ ____ **Pain description**
- Location, onset, VAS, duration, character, aggravating, relieving factors

_____

____ ____ **Conservative Measures including**
- Activity modification, or PT, exercise/classes, NSAIDs/meds, injections, weight loss efforts

_____

____ ____ **Functional limitations – interfering with ADL**
- (mobility, toileting, grooming, dressing, bathing, and eating/food prep)

What is hard to do? _____

_____

_____
Provide Signature
Provider Name: _____

* Answering NO to any of the requirements above, deems the patient currently ineligible to receive APOS therapy. **All must be yes to be eligible**