

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): \_\_\_\_\_

<b>Objective Assessment:</b>			
<b>BF NPRS</b>	<b>/10</b>	<b>Severity:</b>	<b>Follow up #:</b>

**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: \_\_\_\_\_