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: ……

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): _____

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: _____

AposHealth

Dear Patient,

The unique biomechanical device used in AposHealth is designed to relieve pain and improve function, incorporating an element of mild controlled instability. Therefore, it is necessary to observe the following safety precautionary measures, instructions and guidelines while using the device.

Safety Precautionary Measures and Instructions

1. **Never wear the device on dangerous surfaces such as wet or slippery surfaces (including but not limited to, polished floors, tiled floors, ice, and/or snow), gravel, near sharp objects, on rugs, on carpets** (which are not fitted wall to wall) or any other environments, settings or surfaces that may be dangerous, as it may result in falling or injury.
2. **While wearing the device, do not climb up or down stairs (or use escalators) or go outdoors unless instructed by your AposHealth provider.**
3. **You must stop using the device if your medical condition changes, and report any changes in your medical condition, including changes** that are related to the treatment (*e.g.*, any change of / in your stability), to your AposTherapist.
4. Do not drive or operate heavy machinery while wearing/using the device.
5. Avoid carrying any objects while wearing/using the device.
6. Socks should be worn while wearing/using the device.
7. Do not use the device before a specially trained AposTherapist has properly adjusted it. Use of the device should be according to the instructions of the AposTherapist.
8. Only use the device in your existing environment during your daily routine activities, not during enhanced or irregular activities or outside your natural environment, unless specifically instructed otherwise by an AposTherapist.
9. Do not run or play sports that involve constant running and / or fast changes of direction (*e.g.*, basketball or tennis) while wearing/using the device.
10. When being used by a minor, the device may not be used without supervision of an adult who has been advised of the necessary instructions and safety precautions.
11. Use of this product may alter a user's balance and gait, which could increase a user's risk of falling. Users with a history of falls, dizziness, vertigo, muscle weakness, or gait / balance issues, users with disabilities (*e.g.*, neurological disorders, osteoporosis, vision disorders) which may cause falling, and users to whom falling may be extremely dangerous, must take precaution in order to ensure their safety when wearing/using the device (*e.g.*, supervision, walking by a wall / banister).
12. Do not use the device if you suspect that it is faulty or has been damaged. Do not try to repair the device on your own. You are advised to discontinue use immediately and contact your AposHealth provider site.
13. It is forbidden to give, sell, rent, or allow the use of your device to another person.
14. Prior to each use of the device, check / confirm that all parts are properly attached to the sole of the shoe.
15. Should any problem occur as a result of wearing/using the device, you are advised to discontinue use immediately and contact your AposHealth provider site.

AposHealth

Please be advised, if you have not already done so, you must obtain a physician referral specifically for AposHealth in order to continue AposHealth treatment greater than _30_ days after your initial evaluation.

I hereby declare that I have read, understand, and agree to all of the above:

Signature (patient):_____ Date:_____

Print name:_____ DOB: _____

In case of minor, parent / custodian should sign below:

Signature (patient):_____ Date:_____

Print name:_____ DOB: _____

Signature (AposTherapist):_____ Date:_____

Print name:_____

AposHealth

Estimado paciente,

El dispositivo biomecánico único utilizado en AposHealth está diseñado para aliviar el dolor y mejorar la función, incorporando un elemento leve de inestabilidad controlada. Por lo tanto, es necesario observar las siguientes instrucciones y directrices durante el uso del dispositivo.

instrucciones

1. **Nunca use el dispositivo en superficies peligrosas como superficies húmedas o resbaladizas (suelos pulidos, hielo, nieve, etc.), gravilla, cerca de objetos afilados, en alfombras** (que no están instaladas pared a pared) o cualquier otro ambiente cotidiano que pueda ser peligroso, ya que puede resultar en una caída o lesión.
2. **Evite subir o bajar escaleras (o escaleras mecánicas) o salir al aire libre a menos que su proveedor de AposHealth lo indique.**
3. **Debe dejar de usar el dispositivo si su condición médica cambia e informar de cualquier cambio** relacionado con el tratamiento (por ejemplo, cualquier cambio de en su estabilidad) a su AposTerapista.
4. No conduzca ni opere maquinaria pesada mientras utilice el dispositivo.
5. Las medias deben usarse mientras se use el dispositivo.
6. No utilice el dispositivo antes de que un AposTerapista entrenado lo haya ajustado correctamente. El uso del dispositivo debe ser utilizado en acorde con las instrucciones del AposTerapista.
7. Utilice únicamente el dispositivo en su entorno existente durante sus actividades cotidianas, no durante actividades alteradas, irregulares o fuera de su entorno natural, a menos que un AposTerapista indique específicamente lo contrario.
8. No corra ni juegue deportes que impliquen correr constantemente y/o cambios rápidos de dirección (por ejemplo, baloncesto o tenis) con el dispositivo.
9. Cuando es utilizado por un menor de edad, el dispositivo no puede ser utilizado sin la supervisión de un adulto que haya ya sido advertido de las instrucciones necesarias y precauciones de seguridad.
10. El uso de este producto puede alterar el equilibrio y la marcha del unusuario, lo que podría aumentar el riesgo de caída de un usuario. Los usuarios con antecedentes de caídas, mareos, vértigo, debilidad muscular, o problemas de marcha/equilibrio, usuarios con discapacidades (por ejemplo, trastornos neurológicos, osteoporosis, trastornos de la visión) que pueden causar caída, y los usuarios a los que caer pueden ser extremadamente peligroso, deben tomar precauciones con el fin de garantizar su seguridad al utilizar el dispositivo (por ejemplo, supervisión, caminar apoyándose de una pared/barandilla).
11. No utilice el dispositivo si sospecha que está defectuoso o ha sido dañado. No intente reparar el dispositivo por su cuenta.
12. Está prohibido regalar, vender, alquilar o permitir el uso de su dispositivo a otra persona.
13. Antes de cada uso del dispositivo, es posible que desee volver a comprobar y confirmar que las piezas están correctamente ajustadas a la suela del zapato.
14. Si se produce algún problema como resultado del uso del dispositivo, se le recomienda que deje de usarlo inmediatamente y que se ponga en contacto con su proveedor de AposHealth.

AposHealth

Tenga en cuenta que, si aún no lo ha hecho, que debe obtener una orden médica específicamente para AposHealth, para que así pueda continuar con su tratamiento de AposHealth en un periodo mayor _____ días después de su evaluación inicial.

Por la presente declaro que he leído, entendido y aceptado todo lo anterior:

Firma (paciente): _____ Fecha: _____

Nombre en Letra de Molde: _____ DOB: _____

En caso de menor, el padre/custodio debe firmar a continuación:

Firma (paciente): _____ Fecha: _____

Nombre en Letra de Molde: _____ DOB: _____

Firma (AposTerapista):_____ Fecha: _____

Nombre en Letra de Molde: _____

AposHealth® Treatment Program

This first week start with _____ minutes of normal household activities on your feet every day.

Take breaks between each bout of activity.

Increase _____ minutes of being up on your feet weekly.

Additional Notes:_____.

Your Goal

This AposHealth® program is designed just for you, to achieve your goal of:

_____

and is based on your clinical assessment (medical history, gait analysis and questionnaires).

Special instructions:

- During or after use of the shoes you may feel certain physical symptoms like those felt when starting any new physical activity, such as muscle soreness. As your body gets used to the treatment, these symptoms get better.
- If you are experiencing a lot of muscle cramps, fatigue or feel very uncomfortable when wearing the device, decrease the time.
- If the symptoms do not improve, contact your AposHealth® clinic at _____.
- Your success depends on your return for follow-up appointments. AposHealth® treatment requires 5 follow-up appointments within 1 year. The follow-up schedule is as follows:
  - Follow-up 1: Between 1 to 2 weeks after initial appointment
  - Follow-up 2: Around 3-4 weeks after follow-up 1
  - Follow-up 3, 4 and 5: Around 2-3 months apart

- **Your Best Results:** you will achieve the best results when you follow your personalized program, although a tiny bit more or less is fine. You got this!

Your Symptoms

Improvements take time – your symptoms did not arrive overnight so they will not leave immediately. The better you are at following your program, the better you will feel.

Next appointment Date: _____ Time: _____

Next appointment Date: _____ Time: _____

Next appointment Date: _____ Time _____

Programa de tratamiento AposHealth®

Esta primera semana comience con _____ minutos de actividades domésticas normales de pie todos los días.

Tome descansos entre cada serie de actividad.

Aumente _____ los minutos de estar de pie semanalmente.

Notas adicionales:_____.

Su objetivo

Este programa AposHealth® está diseñado solo para usted, para lograr su objetivo de:

_____
y se basa en su evaluación clínica (historial médico, análisis de la marcha y cuestionarios).

Instrucciones especiales:

- Durante o después del uso de los zapatos, es posible que sienta ciertos síntomas físicos como los que siente al comenzar una nueva actividad física, como dolor muscular. A medida que su cuerpo se acostumbra al tratamiento, estos síntomas mejoran.
- Si tiene muchos calambres musculares, fatiga o se siente muy incómodo al usar el dispositivo, disminuya el tiempo.
- Si los síntomas no mejoran, comuníquese con su clínica AposHealth® al _____.
- Su éxito depende de su regreso a las citas de seguimiento. El tratamiento AposTherapy® requiere 5 citas de seguimiento a lo largo de 1 año. El calendario de seguimiento es el siguiente:
  - Seguimiento 1: entre 1 y 2 semanas después de la cita inicial
  - Seguimiento 2: alrededor de 3 a 4 semanas después del seguimiento 1
  - Seguimiento 3, 4 y 5: alrededor de 2 a 3 meses de diferencia

- **Sus mejores resultados:** obtendrá los mejores resultados si sigues su programa personalizado, aunque un poquito más o menos está bien. ¡Usted puede!

Sus síntomas

Las mejoras toman tiempo: sus síntomas no llegaron de la noche a la mañana, por lo que no desaparecerán de inmediato. Cuanto mejor siga su programa, mejor se sentirá.

Próxima cita: Fecha: _____ Hora: _____
Próxima cita: Fecha: _____ Hora: _____
Próxima cita: Fecha: _____ Hora: _____

AposHealth

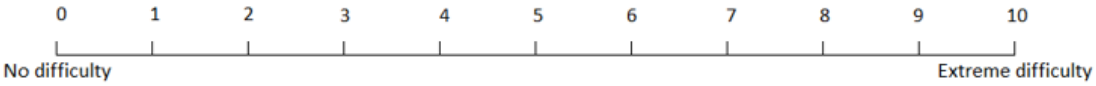
APOS Short Form: Pain and functional limitation Questionnaire

Date: _____ Patient ID number: _____

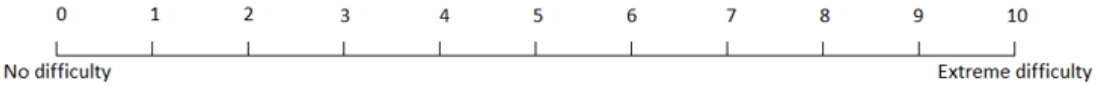
Initial Evaluation/ Follow up number: _____

Think about the difficulty you have experienced completing/ undergoing the following daily physical activities during the past 4 weeks

1. When getting up from a sitting position?



2. While going shopping or traveling outside of your home?



3. During the past 4 weeks, how much did pain interfere with your normal work (including both work outside the home and housework)?
   - ❑ Not at all
   - ❑ Slightly
   - ❑ Moderately
   - ❑ Substantially
   - ❑ Extremely

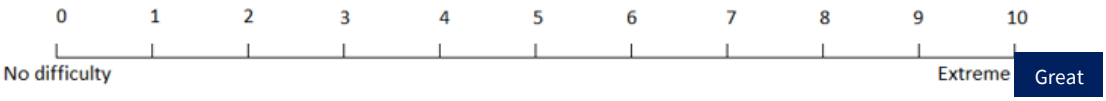
4. Does your health now limit you in walking 100 meters/100 yards?
   - ❑ Yes, limited a lot.
   - ❑ Yes, limited a little
   - ❑ No, not limited at all

5. During the past 4 weeks, how much of the time has your physical health or emotional problems interfered with your social activities (like visiting friends, relatives, etc.)?
    - ❑ All of the time
    - ❑ Most of the time
    - ❑ Some of the time
    - ❑ A little of the time
    - ❑ None of the time

6. Have you felt so down in the dumps nothing could cheer you up?
    - ❑ All of the time
    - ❑ Most of the time
    - ❑ A good bit of the time
    - ❑ Some of the time
    - ❑ A little of the time
    - ❑ None of the time

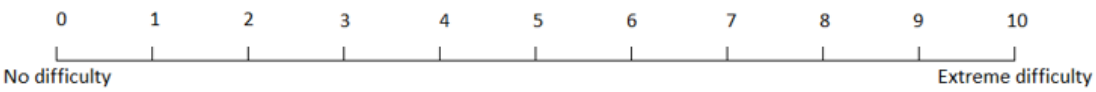
Section B. For Follow-up appointments.

Please rate your satisfaction with AposTherapy to-date?



Section C. For Follow-up appointments.

How likely is it that you would recommend AposTherapy to a friend or colleague?



AposHealth

For Office Use:

Use point values for each question as noted below:

Final score calculations: Severity = (Q1+ Q2+ Q3+ Q4)/4 = _____ Irritability = (Q5+ Q6)/2 = _____	
Question 1 (Q1) Get up from Sitting Response 0 – 100 Response 1 – 90 Response 2 – 80 Response 3 – 70 Response 4 – 60 Response 5 – 50 Response 6 – 40 Response 7 – 30 Response 8 – 20 Response 9 – 10 Response 10 – 0	**Question 2 (Q2)** Shopping Response 0 – 100 Response 1 – 90 Response 2 – 80 Response 3 – 70 Response 4 – 60 Response 5 – 50 Response 6 – 40 Response 7 – 30 Response 8 – 20 Response 9 – 10 Response 10 – 0
Question 3 (Q3) Pain Answer 1 – 100 Answer 2 – 75 Answer 3 – 50 Answer 4 – 25 Answer 5 – 0	**Question 4 (Q4)** Function Answer 1 – 0 Answer 2 – 50 Answer 3 – 100
Question 5 (Q5) Social Activity Answer 1 – 0 Answer 2 – 25 Answer 3 – 50 Answer 4 – 75 Answer 5 – 100	**Question 6 (Q6)** Emotional wellbeing Answer 1 – 0 Answer 2 – 20 Answer 3 – 40 Answer 4 – 60 Answer 5 – 80 Answer 6 – 100

AposHealth

Patient ID: _____

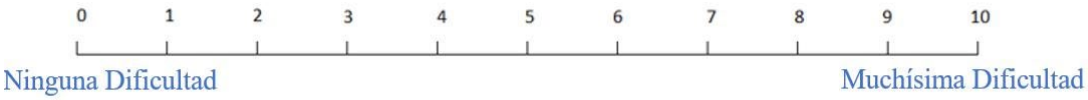
APOS Short form: Pain and Functional limitation questionnaire

Date: _____ **Initial Evaluation/ Follow up number:** _____

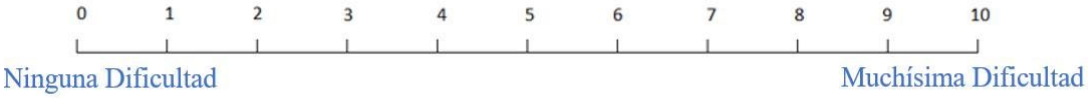
Sección A. Evaluación de dolor y limitación funcional

Piense en la dificultad que ha tenido para completar/ejecutar las siguientes actividades físicas durante las pasadas 4 semanas.

1. ¿Levantarse después de estar sentado?



2. ¿Al salir de compras o fuera de su hogar?



3. ¿Durante las últimas 4 semanas, hasta qué punto su dolor le ha dificultado su rutina cotidiana (incluyendo tareas domésticas y/o trabajo fuera de su hogar)?
   - ❑ Nada
   - ❑ Un poco
   - ❑ Regular
   - ❑ Bastante
   - ❑ Mucho

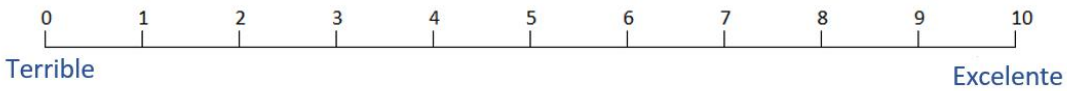
4. ¿Actualmente su estado de salud le limita a caminar 100 pies?
   - ❑ Sí, me limita mucho
   - ❑ Sí, me limita un poco
   - ❑ No, no me limita nada

5. ¿Durante las últimas 4 semanas, con qué frecuencia su salud física y/o problemas emocionales han interferido con sus actividades sociales (tales como visitar a sus amigos y/o familiares)?
   - ❑ Siempre
   - ❑ Casi siempre
   - ❑ Algunas veces
   - ❑ Sólo alguna vez
   - ❑ Nunca

6. ¿Durante las últimas 4 semanas, con qué frecuencia se ha sentido bajo de ánimos?
   - ❑ Siempre
   - ❑ Casi siempre
   - ❑ Muchas veces
   - ❑ Algunas veces
   - ❑ Sólo alguna vez
   - ❑ Nunca

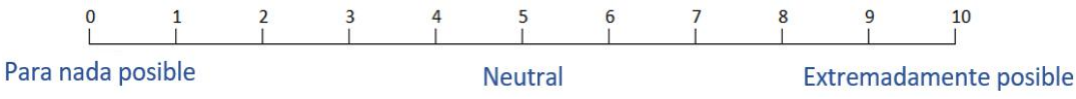
Sección B. Satisfacción del paciente (para seguimientos)

7. Por favor catalogue su nivel de satisfacción con AposTherapy hasta el día de hoy.



Sección C. Puntuación neta del promotor (para seguimientos)

8. Cuál es la probabilidad de usted recomendarle AposTherapy a un familiar, amigo y/o colega?



AposHealth

Patient ID: _____

For Office Use:

Use point values for each question as noted below:

Final score calculations:

1. Severity = (Q1+ Q2+ Q3+ Q4)/4 = _____
2. Irritability = (Q5+ Q6)/2 = _____

Question 1 (Q1) Get up from Sitting Response 0 – 100 Response 1 – 90 Response 2 – 80 Response 3 – 70 Response 4 – 60 Response 5 – 50 Response 6 – 40 Response 7 – 30 Response 8 – 20 Response 9 – 10 Response 10 – 0	**Question 2 (Q2)** Shopping Response 0 – 100 Response 1 – 90 Response 2 – 80 Response 3 – 70 Response 4 – 60 Response 5 – 50 Response 6 – 40 Response 7 – 30 Response 8 – 20 Response 9 – 10 Response 10 – 0
Question 3 (Q3) Pain Answer 1 – 100 Answer 2 – 75 Answer 3 – 50 Answer 4 – 25 Answer 5 – 0	**Question 4 (Q4)** Function Answer 1 – 0 Answer 2 – 50 Answer 3 – 100
Question 5 (Q5) Social Activity Answer 1 – 0 Answer 2 – 25 Answer 3 – 50 Answer 4 – 75 Answer 5 – 100	**Question 6 (Q6)** Emotional wellbeing Answer 1 – 0 Answer 2 – 20 Answer 3 – 40 Answer 4 – 60 Answer 5 – 80 Answer 6 – 100

AposHealth

Telephone Follow-up Record

1 week follow up call / Customer call back / Patient services courtesy call / call taken by therapist

Current treatment plan

Symptoms when wearing system

Symptoms in own footwear

Other relevant information

Advice given / new goals set / action agreed

Further action required

Next Follow-up in_____ weeks Date: _____

Therapist Signature: _____

AposHealth®
(previously AposTherapy®)

Dear Dr. _____

Date _____

Your patient is an ideal candidate for AposHealth® treatment. This physiotherapist-administered device treatment consists of an initial evaluation and calibration followed by follow up sessions for the duration of the treatment. This treatment is covered by several insurance carriers in various states and is also available at a self-pay rate.

We would appreciate it if you can complete the prescription below and return this letter to us via fax or email prior to his/her next appointment so that we may continue to provide AposHealth® treatment.

AposHealth® addresses the biomechanical abnormalities contributing to various orthopedic conditions such as bony malalignment, muscle weakness/bracing, impaired neuromuscular control, and the resulting abnormal pathological movement patterns. AposHealth® has shown in clinical research that patients can achieve pain relief, as well as an improvement in their daily physical function. Visit our website at the link below to view our recently published Reichenback study published in JAMA.

The treatment is based on a foot-worn biomechanical device which is individually calibrated. The clinical assessment to calibrate the device and prescribe duration of treatment includes a computerized spatio-temporal gait analysis, visual gait analysis, pain, function, and quality of life questionnaires (WOMAC, SF-36), subjective interview, and physical examination. The basic premise of treatment is to change load distribution through the lower extremity joints and introduce controlled micro-instability through perturbations (convex pods placed under the forefoot and heel of the device) to stimulate and restore neuromuscular control and, with time, retrain the muscles to adopt an optimal movement pattern. Consequently, the improved movement pattern is shown to reduce pain and improve function. Patients wear the device for approximately an hour a day while performing their normal daily activities.

For further information please feel free to visit our website at www.aposhealth.com/physicians. Additional candidates for AposHealth® may be submitted through the link. We can also be contacted via:

Email: service@aposhealth.com Phone: 855-999-2767

Referral to Physical Therapist for 1 year AposHealth® Treatment

Patient Name:	Patient D.O.B
Date	Phone:
Additional Details:	

Provider Name:	Provider ID:
Practice Name:	Address:
Phone:	Additional Comments:
Provider Signature:	

AposTherapy®

Patient ID: _____

Gait Analysis Form

Patient Name: _____ DOB: _____

Gait analysis details versus normal values

	Date	Date	Date	Date	Date	Date	
Parameters	BF/ Apos	BF/ Apos	BF/ Apos	BF/ Apos	BF/ Apos	BF/ Apos	Normal Values
Exported BF Gait result	☐	☐	☐	☐	☐	☐	
Velocity (cm/s)							**110-140**
Left Step Length (cm)							**55-70**
Right Step Length (cm)							
SL Differential (cm)							**< 1.5**
Left Single Support (%)							**38.5-40.50**
Right Single Support (%)							
SLS Differential (%)							**< 0.7**