

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

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**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)**

- | | |
|-------------------------------------------------------------------------------------|-------------------------------------------------------------|
| <input type="checkbox"/> mostly in the front part of the knee (Left / Right / Both) | <input type="checkbox"/> Lower back (Left / Right / Middle) |
| <input type="checkbox"/> Inner part of the knee (Left / Right / Both) | <input type="checkbox"/> Groin/hip (Left / Right / Both) |
| <input type="checkbox"/> outer part of the knee (Left / Right / Both) | <input type="checkbox"/> Ankle (Left / Right / Both) |
| <input type="checkbox"/> behind the knee/leg (Left / Right / Both) | <input type="checkbox"/> 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?

- | | | | |
|-----------------------------------------------|----------------------------------------------------------|-------------------------------------------|------------------------------------------|
| <input type="checkbox"/> Thyroid | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Heart Conditions | <input type="checkbox"/> lung conditions |
| <input type="checkbox"/> Rheumatoid Arthritis | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Asthma | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> History of cancer | <input type="checkbox"/> Osteoporosis (low bone density) | <input type="checkbox"/> No | |
| <input type="checkbox"/> Other: _____ | | | |

Current medication: _____

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

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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									
<ul style="list-style-type: none">85 all around for size < 4395 all around size ≥ 43	Severe – A ASF ≤ 35 Velocity ≤ 80	Knee <ul style="list-style-type: none">1 line toward soft tissue (patella/tendon, ligaments, muscles)1 line away from joint or meniscus <table><tr><td></td><td>Left</td><td>Right</td></tr><tr><td>A/P:</td><td></td><td></td></tr><tr><td>M/L:</td><td></td><td></td></tr></table>		Left	Right	A/P:			M/L:			Start at flat position
		Left	Right									
	A/P:											
M/L:												
	Moderate – B ASF 36 - 60 Velocity 81-109	Back/Hip OA <ul style="list-style-type: none">2 lines posterior <table><tr><td>Left</td><td>Right</td></tr><tr><td><input type="checkbox"/> P2</td><td><input type="checkbox"/> P2</td></tr></table>	Left	Right	<input type="checkbox"/> P2	<input type="checkbox"/> P2	Start at flat position					
Left	Right											
<input type="checkbox"/> P2	<input type="checkbox"/> P2											
	Mild – C ASF ≥ 61 Velocity ≥ 110	Ankle <ul style="list-style-type: none">1 line toward soft tissue (tendon, ligaments)1 line away from talocrural/subtalar joint <table><tr><td></td><td>Left</td><td>Right</td></tr><tr><td>A/P:</td><td></td><td></td></tr><tr><td>M/L:</td><td></td><td></td></tr></table>		Left	Right	A/P:			M/L:			Start in PF <ul style="list-style-type: none">When lower back is involved – stay in flat
	Left	Right										
A/P:												
M/L:												

Left	Right

Pain location	Heel or *Toe pod position	Flat/PF/DF
Knee *Step length Rule	Pain when the heel comes down: Heel Pod <ul style="list-style-type: none"> Golden Rule: toward soft tissue, away from weight bearing structure 	Go into PF as needed <ul style="list-style-type: none"> PF for pain anywhere posterior leg If lower back is involved and prefers DF– stay in flat
Back	Pain at push off: Toe Pod <ul style="list-style-type: none"> Try moving posterior first Golden Rule second 	DF or PF depending on positional preference
Hip OA		Go into DF
Ankle *Step Length Rule		<ul style="list-style-type: none"> 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

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Final Calibration: Device Size:

<input type="radio"/> Lace <input type="radio"/> Velcro	Pods used		Position		Clicks (N-6)	Spacers	Rationale
			Shift				
Left Toe	<input type="radio"/> 85 <input type="radio"/> 95	<input type="radio"/> A <input type="radio"/> B <input type="radio"/> C	Ant	Post		HS:	
			Med	Lat			
Left Heel	<input type="radio"/> 85 <input type="radio"/> 95	<input type="radio"/> A <input type="radio"/> B <input type="radio"/> C	Ant	Post		HS:	
			Med	Lat			
Right Toe	<input type="radio"/> 85 <input type="radio"/> 95	<input type="radio"/> A <input type="radio"/> B <input type="radio"/> C	Ant	Post		HS:	
			Med	Lat			
Right Heel	<input type="radio"/> 85 <input type="radio"/> 95	<input type="radio"/> A <input type="radio"/> B <input type="radio"/> C	Ant	Post		HS:	
			Med	Lat			
<input type="radio"/> Flat <input type="radio"/> Dorsiflexion due to: <input type="radio"/> Plantarflexion due to:						NPRS in device: /10	
<input type="radio"/> Ipsilateral raise: <input type="radio"/> L <input type="radio"/> 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
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Signature (ATC)..... Licensed Physical Therapist

Name: Date: