MyoPro Candidate Questionnaire

Dear MyoPro Candidate,

Congratulations for having taken this first step toward restoring your independence and activity with the MyoPro powered arm brace. Your O&P clinician (orthotist and/or prosthetist) is working with Myomo, Inc., the high-tech manufacturer of this brace, to determine if this is the right device for you, obtain insurance coverage, and then get you properly fitted and trained to use it. To get started our team needs all the important details about your personal/health history, the cause of your arm weakness, and what you hope for in the future from having your arm motion restored. Please take some time to thoroughly fill out this packet, and return it to your O&P clinician when finished. Your O&P Clinician can help you, if needed.

Demographic Information

Name: _____ Date of Birth: _____ / _____ / _____

Home Address: _____ Sex: ☐ Male ☐ Female

City, State, Zip Code: _____ Height: _____

Home Phone: _____ - _____ - _____ Weight: _____

Work Phone: _____ - _____ - _____ Referring Physician:

Email: _____ _____

Insurance

☐ Medicare ☐ Private Insurance ☐ Workman's Compensation
☐ Medicare Replacement Plan ☐ VA ☐ Other: _____

Name of Primary Insurance: _____ ID#: _____

Secondary / Supplemental Insurance: _____ ID#: _____

Office staff may take copies of your insurance cards for our records.

Describe Your Household (check all that apply)

☐I live alone ☐Other, briefly describe living situation:_____

☐Married, living with spouse _____

☐Living with significant other _____

☐Divorced or otherwise separated _____

☐Living with my children, list their ages: ☐Boys, ages:_____ ☐Girls, ages:_____

☐ Living with other relatives. List relations:_____

☐Living with non-related roommates, how many?_____

Independence Level (choose situation that best describes you & who helps you if needed)

☐ I require *no help* from others for any daily activities.

☐I require help for *only occasional activities, but not every day*. → ☐ Family & friends help me ☐ Paid staff help me

☐I require help for *just a few activities every day* → ☐ Family & friends help me ☐ Paid staff help me

☐I require help for *most activities every day* → ☐ Family & friends help me ☐ Paid staff help me

Patient Name: _____

Employment Status (check all that apply and describe)

☐ Retired ☐ Unemployed ☐ On Disability ☐ Student; where?: _____

☐ Employed: Where and Type of Job(s): _____

_____

Timeframe at most recent main job: From (month, year) _____To:_____

List examples of daily work responsibilities**:** _____

_____

Personal Background

Where were you born? _____ Where do you say you are from? _____

What is your highest level of education?

☐ high school diploma / GED ☐Some college, no degree

☐Certificate course(s), in _____

☐Associates degree(s), in _____

☐College degree(s), in _____

☐Graduate degree(s), in _____

Medications (list only names of all medicatioins you are sure you take, dosage not needed)

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Past Medical History (list any chronic conditions treated or surgeries, with years done)

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Allergies to any materials against your skin? ☐No ☐ Yes:_____

Patient Name: _____

History of Arm Weakness / Medical Record Look-up

Which arm(s) is(are) weak? ☐ Both ☐ Right only ☐ Left only

Since when have you had arm weakness (month, day, year if known): _____

Why do you have arm weakness? _____

When it happened, were you initially treated at a hospital? ☐ NO or ☐Yes*

Were you admitted to any other hospital(s) later just for rehab? ☐ NO or ☐Yes*

Did you get outpatient (at home, in a clinic) occupational therapy later on? ☐ NO or ☐YES*

*If you answered "yes" to any of the above, please list the names of the hospitals/clinics, any supervising physicians' names you can remember, and approximate months and years of your time being treated there. Do your best to recall the information, if you can't remember, write a "?" mark.

Hospital/Clinic name	Doctor/Therapists' Names	~Month, Year
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Ongoing Problems in Your *Weak Arm(s)* (check all that apply & describe as appropriate)

☐Spasticity → Treatments tried: ☐Injections (e.g. Botox) ☐Oral meds ☐Surgery; year?: _____

☐Contractures → Treatments tried: ☐Casting ☐ Ultrasound ☐Braces ☐Surgery, year?: _____

☐Chronic arm pain; describe (e.g. "sharp, tingly, burning, achy"): _____

Is the chronic pain: ☐Constant, **or** ☐Coming-and-going

Where do you feel it? _____

What makes it worse? _____

What makes it better? _____

Rate *worst level* of pain on a 0-10 scale (0 = no pain, 10 = max imaginable): _____

Rate *least level* of pain on a 0-10 scale (0 = no pain, 10 = max imaginable): _____

☐Shoulder separation

☐Non-healing wounds

☐Non-healing broken bones

☐Others:_____

Previous Treatment History – Personal experience						
		Brace for Positioning	A Brace which Moves	Occupational Therapy	Electrical Stimulation	Botox
Have you had the following treatments for your affected arm, shoulder or hand?		☐ No	☐ No	☐ No	☐ No	☐ No
		☐ Yes	☐ Yes	☐ Yes	☐ Yes	☐ Yes
How long did you use this type of treatment (# of months or years)?						
How effective was this treatment in **improving the function** of your effected arm, shoulder, or hand?	Not at All	☐ NA	☐ NA	☐ NA	☐ NA	☐ NA
	Very Poor	☐ 1	☐ 1	☐ 1	☐ 1	☐ 1
	Poor	☐ 2	☐ 2	☐ 2	☐ 2	☐ 2
	Good	☐ 3	☐ 3	☐ 3	☐ 3	☐ 3
	Very Good	☐ 4	☐ 4	☐ 4	☐ 4	☐ 4
	Excellent	☐ 5	☐ 5	☐ 5	☐ 5	☐ 5

Problems in Your *Stronger Arm* (check all that apply)

☐ My arms are equally weak on both sides

☐ Arthritis; in which joints?: ☐Shoulder ☐ Elbow ☐Wrist ☐Fingers

☐ Rotator cuff injury. List treatments: ☐Therapy ☐ Injections ☐Surgery; year?: _____

☐ Carpal tunnel syndrome. Treatments: ☐Braces ☐ Injections ☐ Surgery; year?: _____

Hand Dominance: Without your arm weakness, are you normally?

☐ Right handed ☐ Left handed ☐ I used both hands equally

External Walking Aids (Check all that you use currently)

☐ None	☐ Cane	☐ Walker
☐ Wheelchair	☐ Crutches	☐ WalkAide or BioNess
☐ Ankle-Foot Brace (AFO)	☐ Knee-Ankle-Foot Brace (KAFO)	
☐ Others:		

In the past year, have you fallen? ☐ No ☐ Yes

If Yes, how many times have you fallen? _____

Were you hospitalized due to your fall(s)? ☐ No ☐ Yes

Were your falls related to not having full function in your affected arm?

☐ No ☐ Yes, explain: _____

Please give us a list of specific goals you hope to achieve by having your arm function restored with a device like Myopro. Be as specific as possible to *your individual lifestyle*, **and try to think of at least 3 things** for each of the two sections that follow.

Patient Name: _____

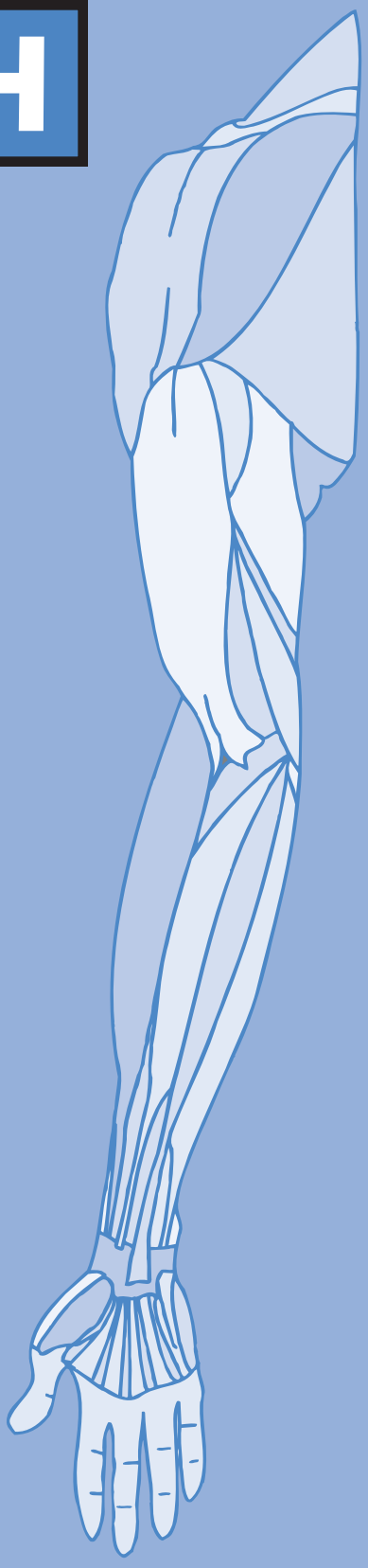
Personal and recreational goals (e.g., taking care of your home, caring for a child or sick family member, sports, hobbies, or any leisurely pursuit you no longer do as well as you would like):

Work goals (e.g. returning to full or part-time work, performing *specific aspects* of your job better, increase your income, financially support family, change job fields, achieve some specific professional milestone, etc.): _____

Thank-you for your time in thoroughly completing this packet. Please give it to your O&P clinician, and sign the *Release of Medical Records* so we can gather your related medical information.

Patient Name: _____

THE DASH



INSTRUCTIONS

This questionnaire asks about your symptoms as well as your ability to perform certain activities.

Please answer *every question*, based on your condition in the last week, by circling the appropriate number.

If you did not have the opportunity to perform an activity in the past week, please make your *best estimate* on which response would be the most accurate.

It doesn't matter which hand or arm you use to perform the activity; please answer based on your ability regardless of how you perform the task.

Disabilities of the Arm, Shoulder and Hand

Please rate your ability to do the following activities in the last week by circling the number below the appropriate response.

	NO DIFFICULTY	MILD DIFFICULTY	MODERATE DIFFICULTY	SEVERE DIFFICULTY	UNABLE
1. Open a tight or new jar.	1	2	3	4	5
2. Write.	1	2	3	4	5
3. Turn a key.	1	2	3	4	5
4. Prepare a meal.	1	2	3	4	5
5. Push open a heavy door.	1	2	3	4	5
6. Place an object on a shelf above your head.	1	2	3	4	5
7. Do heavy household chores (e.g., wash walls, wash floors).	1	2	3	4	5
8. Garden or do yard work.	1	2	3	4	5
9. Make a bed.	1	2	3	4	5
10. Carry a shopping bag or briefcase.	1	2	3	4	5
11. Carry a heavy object (over 10 lbs).	1	2	3	4	5
12. Change a lightbulb overhead.	1	2	3	4	5
13. Wash or blow dry your hair.	1	2	3	4	5
14. Wash your back.	1	2	3	4	5
15. Put on a pullover sweater.	1	2	3	4	5
16. Use a knife to cut food.	1	2	3	4	5
17. Recreational activities which require little effort (e.g., cardplaying, knitting, etc.).	1	2	3	4	5
18. Recreational activities in which you take some force or impact through your arm, shoulder or hand (e.g., golf, hammering, tennis, etc.).	1	2	3	4	5
19. Recreational activities in which you move your arm freely (e.g., playing frisbee, badminton, etc.).	1	2	3	4	5
20. Manage transportation needs (getting from one place to another).	1	2	3	4	5
21. Sexual activities.	1	2	3	4	5

Disabilities of the Arm, Shoulder and Hand

	NOT AT ALL	SLIGHTLY	MODERATELY	QUITE A BIT	EXTREMELY
22. During the past week, *to what extent* has your arm, shoulder or hand problem interfered with your normal social activities with family, friends, neighbours or groups? *(circle number)*	1	2	3	4	5

	NOT LIMITED AT ALL	SLIGHTLY LIMITED	MODERATELY LIMITED	VERY LIMITED	UNABLE
23. During the past week, were you limited in your work or other regular daily activities as a result of your arm, shoulder or hand problem? *(circle number)*	1	2	3	4	5

Please rate the severity of the following symptoms in the last week. *(circle number)*

	NONE	MILD	MODERATE	SEVERE	EXTREME
24. Arm, shoulder or hand pain.	1	2	3	4	5
25. Arm, shoulder or hand pain when you performed any specific activity.	1	2	3	4	5
26. Tingling (pins and needles) in your arm, shoulder or hand.	1	2	3	4	5
27. Weakness in your arm, shoulder or hand.	1	2	3	4	5
28. Stiffness in your arm, shoulder or hand.	1	2	3	4	5

	NO DIFFICULTY	MILD DIFFICULTY	MODERATE DIFFICULTY	SEVERE DIFFICULTY	SO MUCH DIFFICULTY THAT I CAN'T SLEEP
29. During the past week, how much difficulty have you had sleeping because of the pain in your arm, shoulder or hand? *(circle number)*	1	2	3	4	5

	STRONGLY DISAGREE	DISAGREE	NEITHER AGREE NOR DISAGREE	AGREE	STRONGLY AGREE
30. I feel less capable, less confident or less useful because of my arm, shoulder or hand problem. *(circle number)*	1	2	3	4	5

DASH DISABILITY/SYMPTOM SCORE = $\left[\left(\frac{\text{sum of n responses}}{n}\right) - 1\right] \times 25$, where n is equal to the number of completed responses.

A DASH score may <u>not</u> be calculated if there are greater than 3 missing items.

DISABILITIES OF THE ARM, SHOULDER AND HAND

WORK MODULE (OPTIONAL)

The following questions ask about the impact of your arm, shoulder or hand problem on your ability to work (including home-making if that is your main work role).

Please indicate what your job/work is:_____

❒ I do not work. (You may skip this section.)

Please circle the number that best describes your physical ability in the past week. Did you have any difficulty:

	NO DIFFICULTY	MILD DIFFICULTY	MODERATE DIFFICULTY	SEVERE DIFFICULTY	UNABLE
1. using your usual technique for your work?	1	2	3	4	5
2. doing your usual work because of arm, shoulder or hand pain?	1	2	3	4	5
3. doing your work as well as you would like?	1	2	3	4	5
4. spending your usual amount of time doing your work?	1	2	3	4	5

SPORTS/PERFORMING ARTS MODULE (OPTIONAL)

The following questions relate to the impact of your arm, shoulder or hand problem on playing *your musical instrument or sport or both*. If you play more than one sport or instrument (or play both), please answer with respect to that activity which is most important to you.

Please indicate the sport or instrument which is most important to you:_____

❑ I do not play a sport or an instrument. (You may skip this section.)

Please circle the number that best describes your physical ability in the past week. Did you have any difficulty:

	NO DIFFICULTY	MILD DIFFICULTY	MODERATE DIFFICULTY	SEVERE DIFFICULTY	UNABLE
1. using your usual technique for playing your instrument or sport?	1	2	3	4	5
2. playing your musical instrument or sport because of arm, shoulder or hand pain?	1	2	3	4	5
3. playing your musical instrument or sport as well as you would like?	1	2	3	4	5
4. spending your usual amount of time practising or playing your instrument or sport?	1	2	3	4	5

SCORING THE OPTIONAL MODULES: Add up assigned values for each response; divide by 4 (number of items); subtract 1; multiply by 25.
An optional module score may <u>not</u> be calculated if there are any missing items.

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Myomo, Inc., Release of Medical Records and Designation as Representative for Insurance Appeals

I, _____, certify that I am seeking treatment for orthotic care by orthotic provider _____ and ***Myomo, Inc***. As such I recognize they are both covered entities under HIPAA, with legitimate needs to access my medical records and responsibilities to protect my privacy. I knowingly release to both of them any and all medical records required to ascertain the medical necessity of the care being provided to me, as well as any and all medical records required to pursue insurance coverage for those services.

Patient Signature: _____ Today's Date: _____

Printed Name: _____ Date of Birth: _____

Authorization and Designation of Insurance Representative

I, _____, do hereby designate, authorize and convey to orthotic provider _____ , and ***Myomo, Inc.***, to the full extent permissible under law and under any applicable insurance policy and/or employee health care benefit plan, the right and ability to act on my behalf in connection with any appeal for denied proposed healthcare services (e.g. prior authorization) or denied claim for said services that I may have under such insurance policy and/or any employee health care benefit plan – including but not limited to, the right to act in my behalf in respect to an employee health care benefit plan governed by the Employee Retirement Income Security Act of 1974.

Patient Signature: _____ Today's Date: _____

Printed Name: _____ Date of Birth: _____

Patient Name: _____