

## 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: <input type="checkbox"/> Male <input type="checkbox"/> Female
City, State, Zip Code: _____	Height: _____
Home Phone: _____ - _____ - _____	Weight: _____
Work Phone: _____ - _____ - _____	Referring Physician: _____
Email: _____	_____
Insurance	
<input type="checkbox"/> Medicare <input type="checkbox"/> Private Insurance <input type="checkbox"/> Workman's Compensation <input type="checkbox"/> Medicare Replacement Plan <input type="checkbox"/> VA <input type="checkbox"/> 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)	
<input type="checkbox"/> I live alone	<input type="checkbox"/> Other, briefly describe living situation: _____
<input type="checkbox"/> Married, living with spouse	_____
<input type="checkbox"/> Living with significant other	_____
<input type="checkbox"/> Divorced or otherwise separated	_____
<input type="checkbox"/> Living with my children, list their ages: <input type="checkbox"/> Boys, ages: _____ <input type="checkbox"/> Girls, ages: _____	
<input type="checkbox"/> Living with other relatives. List relations: _____	
<input type="checkbox"/> Living with non-related roommates, how many? _____	
Independence Level (choose situation that best describes you & who helps you if needed)	
<input type="checkbox"/> I require <i>no help</i> from others for any daily activities.	
<input type="checkbox"/> I require help for <i>only occasional activities, but not every day.</i> → <input type="checkbox"/> Family & friends help me <input type="checkbox"/> Paid staff help me	
<input type="checkbox"/> I require help for <i>just a few activities every day</i> → <input type="checkbox"/> Family & friends help me <input type="checkbox"/> Paid staff help me	
<input type="checkbox"/> I require help for <i>most activities every day</i> → <input type="checkbox"/> Family & friends help me <input type="checkbox"/> 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 medications 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: \_\_\_\_\_





**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):

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**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.): \_\_\_\_\_

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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

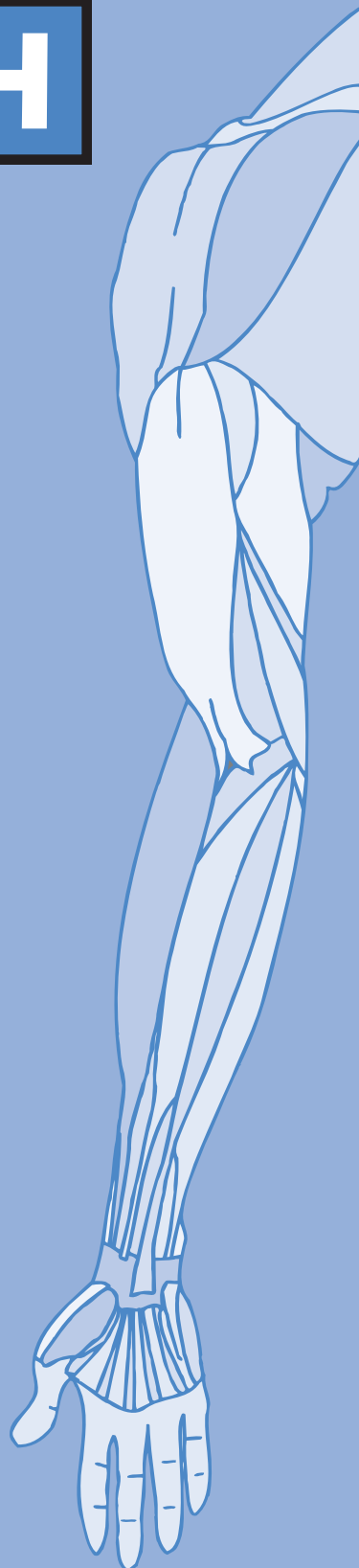
## INSTRUCTIONS

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, <i>to what extent</i> has your arm, shoulder or hand problem interfered with your normal social activities with family, friends, neighbours or groups? <i>(circle number)</i>	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? <i>(circle number)</i>	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? <i>(circle number)</i>	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. <i>(circle number)</i>	1	2	3	4	5

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

A DASH score may not 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 not be calculated if there are any missing items.**



**Institute  
for Work &  
Health**

Research Excellence  
Advancing Employee  
Health

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

Parent/Legal Rep (if patient cannot sign): \_\_\_\_\_ Date: \_\_\_\_\_

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

Parent/Legal Rep (if patient cannot sign): \_\_\_\_\_ Date: \_\_\_\_\_

**Patient Name:** \_\_\_\_\_