MyoPro Candidate Questionnaire

Patient Information

Demographics / Cognition	
Patient Name:_____ **Date of Birth:**_____ **Funding Channel:** ☐ Insurance (Medicare Advantage, Medicaid, Commercial) ☐ Medicare Part B ☐ Veteran Affairs (VA) ☐ Cash Pay **Cognition:** Alert and Oriented x___ (Please indicate 0-4)	
Social History	
Who do you live with?	
Do you have a family member/friend who is your caregiver?	☐ Yes ☐ No
Do you have a paid caregiver at home?	☐ Yes ☐ No
Is your caregiver (family member or paid caregiver) willing and able to assist you with the MyoPro?	☐ Yes ☐ No
Are you willing to allow your caregiver (family member or paid caregiver) to assist you with the MyoPro?	☐ Yes ☐ No
How often is your caregiver available (e.g., days per week)?	
Are you currently employed? If yes, please specify:	☐ Yes ☐ No

Healthcare Provider History

Primary Care Physician	
Primary Care Physician (PCP) Name: Clinic Name / City, State: Dates of Treatment:	
Specialists (Example: Neurologist, Physiatrist, Surgeon)	
1. Provider's Name / Specialty: Clinic Name / City, State: Dates of Treatment:	
2. Provider's Name / Specialty: Clinic Name / City, State: Dates of Treatment:	
3. Provider's Name / Specialty: Clinic Name / City, State: Dates of Treatment:	
Additional notes (regarding primary care or specialty treatment history):	

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Therapy Information

Treatment History				
	Occupational Therapy	**Static or Dynamic Brace**	**Electrical Stimulation**	**Botox**
Have you had the following treatment for your affected arm?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
When did you last have or use this treatment?				
For current Botox patients, how often do you receive it?				
Additional notes:				

Current Therapy Information	
Are you currently in therapy? Therapy Clinic: City / State: Dates of Treatment:	☐ Yes ☐ No
Previous Therapy History (Including Inpatient, Outpatient, Home Health, etc.)	
Initial Admission Hospital: City, State: Dates of Treatment:	
Therapy Clinic: City / State: Dates of Treatment:	
Therapy Clinic: City / State: Dates of Treatment:	
Therapy Clinic: City / State: Dates of Treatment:	
Therapy Clinic: City / State: Dates of Treatment:	
Additional notes:	

Patient Name: _____

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Additional Information

Mobility Aides

☐ None
☐ Power Wheelchair
☐ Manual Wheelchair
☐ Ankle-Foot Brace (AFO)
☐ Cane
☐ Crutches
☐ Knee-Ankle-Foot Brace (KAFO)
☐ Walker
☐ WalkAide or Bioness
☐ Other(s):

Precautions

Do you have any conditions that would require our staff to take extra precautions, such as any respiratory or blood borne infectious disease?

☐ Yes ☐ No

If Yes, please note:

Goals

Patient Goals

Please list three (3) or more ADL/IADL goals:

Remote Measurement

Shape Capture Details – Qualified Patients Only

Do you recommend the measurements be done in-person?

☐ Yes ☐ No

If you selected Yes, please specify a reason:

☐ Anatomical – patient has a unique anatomy (e.g. fused wrist)
☐ Support – patient does not have a caregiver or helper to assist
☐ Other (Please Specify):

Patient Name: _____

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Additional Information

Please complete and upload the following:
• Active Range of Motion (AROM) photos • EMG Graphs (for in-person screenings) • Click to complete: Brief Interview for Mental Status (BIMS) (if applicable)

Additional Notes (if needed)

By signing, you certify this accurately represents the patient's medical history and treatment.	
Signature:	Date:
Clinician Printed Name (including credentials):	
Company:	
Address:	
Phone Number:	
Clinician Email:	

Patient Name: _____