

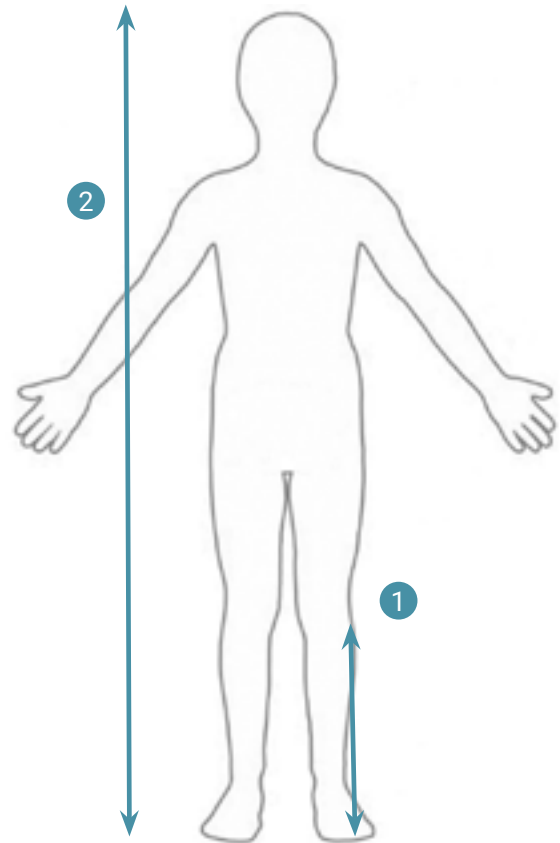
MEASUREMENT FORM

INNOWALK PRO

USER NAME		DATE OF MEASUREMENT	
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PHYSIOTHERAPIST	
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MEASUREMENTS		
Measurement 1 LOWER LEG (CM) (SOLE OF SHOE TO CENTRE OF KNEE JOINT)		cm
Measurement 2 OVERALL HEIGHT (CM)		cm



Diagnosis	
Relevant history	
Orthoses	
Other equipment	

NOTE
ALL MEASUREMENTS SHOULD BE TAKEN WITH FOOTWEAR ON

PRE-SCREEN CHECKLIST	COMMENTS / ACTION		
Seizures			
Known low bone mineral density			
Sensory impairment			
Leg length discrepancy	SHORTER SIDE: RIGHT	LEFT	DIFFERENCE IN CM _____
Communication aids			

PERSONAL SETTINGS



INNOWALK PRO M	INNOWALK PRO L
USER NAME	DATE OF MEASUREMENT
PHYSIOTHERAPIST	

SEATING	COMMENTS
SEAT HEIGHT	
SEAT DEPTH	
SPASM CONTROL (RANGE 0-6)	
TILT IN SPACE	

CHEST SUPPORT	LEFT	RIGHT	COMMENTS
HEIGHT			
WIDTH			

LEG SUPPORT	LEFT	RIGHT	COMMENTS
FOOT PLATE POSITION ON SKI			
FOOT PLATE WIDTH POSITION			
LEG SUPPORT HEIGHT			
CAM STOP HYPEREXTENSION BLOCK IN USE	Yes No	Yes No	
LEG LENGTH DISCREPENCY SOLES IN USE	Yes No	Yes No	

GUIDE-STRAP	COMMENTS
TENSION ON GUIDE-STRAP	
NUMBER LOOP ON THE GUIDE-STRAP	

HIP SUPPORT	LEFT	RIGHT	COMMENTS
HIP SUPPORT HEIGHT			
HIP SUPPORT WIDTH			

SUPPORT EQUIPMENT	LEFT	RIGHT	COMMENTS
SHOULDER STRAPS	Yes No	Yes No	
TRAY	Yes No	Yes No	
NECK SUPPORT	Yes No	Yes No	
ARM MOVEMENT HANDLES	Yes No	Yes No	
HAND FIXATION GLOVES	Yes No	Yes No	

EXERCISE PRESCRIPTION	COMMENTS
DURATION	
TIME/SESSION	
TIME/WEEK	
MIN/MAX SPEED	