

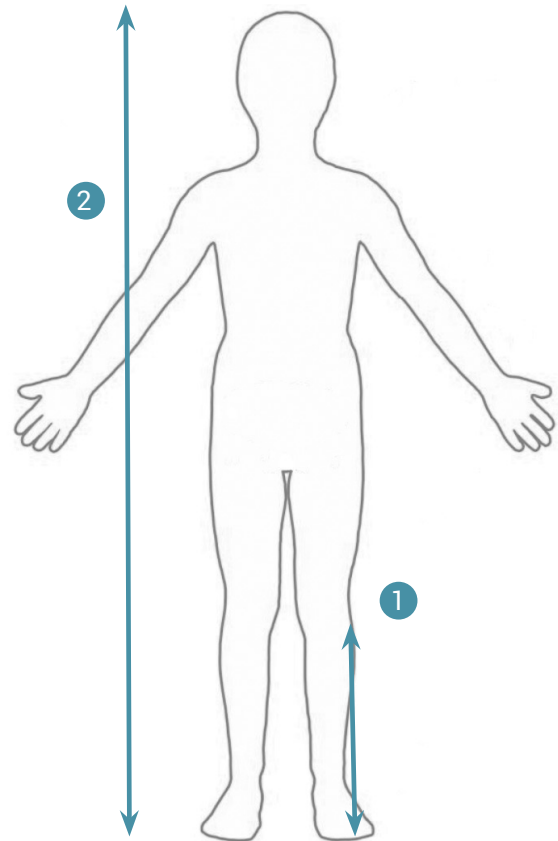
# MEASUREMENT FORM

INNOWALK PRO

USER NAME		DATE OF MEASUREMENT	
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PHYSIOTHERAPIST	
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MEASUREMENTS		
<b>Measurement 1</b> LOWER LEG (CM)  (SOLE OF SHOE TO CENTRE OF KNEE JOINT)		cm
<b>Measurement 2</b> 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			
PHYSIOTHERAPIST		DATE OF MEASUREMENT	
<b>SEATING</b>		<b>COMMENTS</b>	
SEAT HEIGHT			
SEAT DEPTH			
SPASM CONTROL (RANGE 0-6)			
TILT IN SPACE			
<b>CHEST SUPPORT</b>		<b>LEFT</b>	<b>RIGHT</b>
HEIGHT			
WIDTH			
<b>LEG SUPPORT</b>		<b>LEFT</b>	<b>RIGHT</b>
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
LEG SUPPORT PADDING STRAP TENSION		1st 2nd 3rd	1st 2nd 3rd
LEG SUPPORT PADDING TYPE		Thin Thick	Thin Thick
<b>GUIDESTRING</b>		<b>COMMENTS</b>	
TENSION/LOOP ON GUIDESTRING			
<b>HIP SUPPORT</b>		<b>COMMENTS</b>	
HIP SUPPORT HEIGHT		Narrow Wide	
HIP SUPPORT WIDTH		High notch Low notch	
		<b>LEFT</b>	<b>RIGHT</b>
HIP SUPPORT HEIGHT			
HIP SUPPORT WIDTH			
<b>SUPPORT EQUIPMENT</b>		<b>COMMENTS</b>	
SHOULDER STRAPS		Yes No	
TRAY		Yes No	
NECK SUPPORT		Yes No	
ARM MOVEMENT HANDLES		<b>Yes</b> <b>No</b>	
HAND FIXATION GLOVES		Yes No	
<b>EXERCISE PRESCRIPTION</b>		<b>COMMENTS</b>	
STANDING POSITION - GONIOMETER (1-10)			
DURATION			
<b>TIME/SESSION</b>			
TIME/WEEK			
MIN/MAX SPEED			