

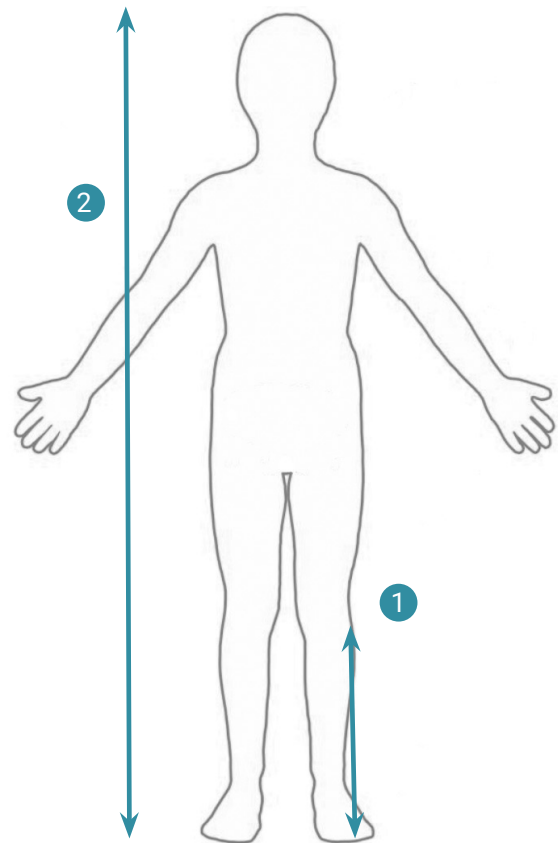
MEASUREMENT FORM

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	<input type="radio"/>			
Known low bone mineral density	<input type="radio"/>			
Sensory impairment	<input type="radio"/>			
Leg length discrepancy	<input type="radio"/>	SHORTER SIDE: RIGHT <input type="radio"/>	LEFT <input type="radio"/>	DIFFERENCE IN CM _____
Communication aids	<input type="radio"/>			

PERSONAL SETTINGS

INNOWALK PRO M	<input type="radio"/>	INNOWALK PRO L	<input type="radio"/>
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USER NAME	
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PHYSIOTHERAPIST		DATE OF MEASUREMENT	
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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 <input type="radio"/> No <input type="radio"/>	Yes <input type="radio"/> No <input type="radio"/>	
LEG LENGTH DISCREPENCY SOLES IN USE	Yes <input type="radio"/> No <input type="radio"/>	Yes <input type="radio"/> No <input type="radio"/>	
LEG SUPPORT PADDING STRAP TENSION	1st <input type="radio"/> 2nd <input type="radio"/> 3rd <input type="radio"/>	1st <input type="radio"/> 2nd <input type="radio"/> 3rd <input type="radio"/>	
LEG SUPPORT PADDING TYPE	Thin <input type="radio"/> Thick <input type="radio"/>	Thin <input type="radio"/> Thick <input type="radio"/>	

GUIDESTRING	COMMENTS
LOOP ON GUIDESTRING	1 <input type="radio"/> 2 <input type="radio"/> 3 <input type="radio"/> 4 <input type="radio"/> 5 <input type="radio"/>
TENSION	

HIP SUPPORT	LEFT	RIGHT	COMMENTS
HIP SUPPORT HEIGHT			
HIP SUPPORT WIDTH			

SUPPORT EQUIPMENT			COMMENTS
SHOULDER STRAPS	Yes <input type="radio"/> No <input type="radio"/>		
TRAY	Yes <input type="radio"/> No <input type="radio"/>		
NECK SUPPORT	Yes <input type="radio"/> No <input type="radio"/>		
ARM MOVEMENT HANDLES	Yes <input type="radio"/> No <input type="radio"/>		
HAND FIXATION GLOVES	Yes <input type="radio"/> No <input type="radio"/>		

EXERCISE PRESCRIPTION	COMMENTS
STANDING POSITION - GONIOMETER (1-10)	
DURATION	
TIME/WEEK	
MIN/MAX SPEED	