Medical Restrictions/ Modified Use of Standard Infinity Walk Method

Dear Medical Professional:

Your patient, _____ (print legal name), wishes to participate in a self-improvement program called INFINITY WALK that includes a bilaterally balanced natural walking pattern, to which multi-tasking skills are added. A brief description follows:

Infinity Walk Standard Use Method (assuming no physical/medical limitations):

Start by walking in a figure-eight pattern. The size of the figure eight space walked for an adult is at least 10 feet by 7 feet. More speed requires greater space. A minimum of seven steps is recommended to complete each of the two circles that comprise the full figure-eight walking pattern. While continuously walking in a figure eight, a person may add lateral eye tracking and neck turning. (Ask for photos or illustrations of this.) Other motor, sensory, perceptual, verbal, and cognitive skills may also be included in various multi-tasking combinations. Speed and duration of Infinity Walking is normally unrestricted, unless part of training. A flat indoor or outdoor walking surface is recommended.

Please indicate below any physical restrictions you have assessed that would require your patient to modify the standard Infinity Walk method. Your patient is expected to take self-responsibility for any Infinity Walk practice unless a medical professional is present and explicitly assumes the responsibility for use of this method with your patient. Your patient is expected to follow all guidelines and modifications that you indicate below. Your patient should keep a copy of this completed form.

____ No known restrictions at this time

____ Walking surface must be completely flat and level

____ Use Infinity Walk with weight bearing support railing (i.e. Infinity WalkAbout railing).

____ May use Infinity Walk only with non-weight bearing assistive means (pool, horse, motorized chair or stroller, wagon, wheelchair pushed or pulled by another person).

____ Practice limited to medical facility and / or in presence of medical personnel.

____ A responsible adult should be present / nearby, including during home practice. (circle one)

____ Time/endurance restrictions: _____

____ Joint rotation restrictions (cervical thoracic): _____

____ Joint rotation restrictions (lower extremities): _____

____ Other medical restrictions: (e.g. seizures, vertigo, visual) _____

____ Additional Modifications/Restrictions:

_____	_____	_____	_____
DATE	PRINT PROFESSIONAL'S NAME	MEDICAL PROFESSIONAL'S SIGNATURE	CLINICAL DEGREE