

**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 approximately 11 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