# Monthly TENS Patient Management

Name: ______________________________ Phone: ______________________

Physician: ____________________________________________________

Model of TENS: ________________________________________________

Pain is presently: ☐ Competely gone ☐ Much Improved
☐ Unchanged ☐ Decreased initaly, but now worst

TENS is being used: ☐ Daily ☐ Inermittenly ☐ As needed for pain

If daily, now many hours per day: ☐ Less then 8 ☐ 8-12 ☐ 12-16 ☐ More then 16

Have you noted a change or improvement in any of the following:
☐ Activity ☐ Posture ☐ Strength ☐ Less Medication ☐ No Change

Rate you current pain level (1=low, 10=high): 1 2 3 4 5 6 7 8 9 10

The last supplies purchased were: ☐ Adequate ☐ Too Much ☐ Not Enough

Allergic of skin reactions - note if any:

A physician visit should be planned for: ______________________________________

I will call you again on: Date__________________ At: ____________☐A.M - ☐P.M

Comments / Recommendations:

Signed: ______________________________ Date: ______________________