



Monthly TENS Unit Progress Report for BWC Patient

Completion of this form or substitute documentation containing all elements of this form is required monthly by the BWC.

Patient Name: _____ BWC Claim Number: _____

Physician: _____

1. Are you comfortable with the application and use of your TENS unit?

2. How many hours per day do you use your TENS unit? _____
3. How many days per week do you use your TENS unit? _____
4. On a scale of 0-10, 0 being no pain and 10 being severe pain, what is your pain level prior to applying your TENS unit? _____
5. On the same pain scale, what is your pain level after using the TENS unit? _____

6. Have you received less pain medication by using your TENS unit?: Yes _____ No _____
7. Does the TENS unit allow you to participate in activities which you were previously limited by pain?: Yes _____ No _____. If yes, please describe: _____

8. Are you experiencing any skin reactions?: Yes _____ No _____. If yes, please describe: _____

9. Who is the supplier for your TENS unit/supplies? _____
10. Is your TENS unit a two-lead or a four-lead wires unit?: Two-lead _____ Four-lead _____
11. Do you receive TENS unit supplies from any supplier other than the vendor listed above?

Patient Signature: _____ Date: _____