Weekly Tracking Sheet (TS) – Assess Your Progress beginning today (baseline) and for 12 weeks.

Therapy Target(s): ☐ Daily ☐ Nightly ☐ Urgency ☐ Trips ☐ Leakage ☐ Incontinence ☐ Other

_____

My Definition of Success/Primary Objective: Reduce_____ from _____ to _____

Examples: Eliminate leakage. Reduce night trips from 3 to 1. Make it through church without urgency. Reduce pad use.

Complete one row each week on your report day. *(This form is oriented to TNS therapies. Use the portion applicable to your therapy.)*

Planned Treatments (#/week at start):_____. Duration _____Minutes. Note changes from plan in Comments.

Report No. (#1 = Baseline)	Rpt Day(Letter) Date (Mo/Day)	Total Sessions this past week	Used Template (Y, N, N/A)	Today - Start Intensity	# of intensity Increases	Today - End Intensity	Electrodes New (N) / used (U)	# Toilet Trips Last Night	# Incontinence /Leakage/24 H	Symptoms vs Prior Week Better, Same,	**Stimulation Device-Make: _____Model_____ Therapy: ☐ PTNS ☐ TTNS ☐ Vivally ☐ Other _____ Comments (Schedule changes? Side effects? Device, electrode, needle, template, or intensity issues? Other observations?)**
1											**Other Baseline?**
2											
3											
4											
5											
6											
7											
8											
9											
10											
11											
12											
13											

After your trial, complete the questionnaire on the reverse.

Completion Questionnaire (CQ)

Please complete this at the conclusion of your therapy exploration period. This questionnaire is to organize observations about OAB therapies. Negative reports are equally important as positive, helping to define what works and what does not. Send your information in the supplied envelope to **OAB Therapy 101, P.O. Box 211, Novi, MI 48376. THANK YOU**! We appreciate your assistance in improving understanding.

1. Therapy Explored
☐ PTNS
☐ TTNS using a TENS device
☐ Vivally
☐ Implantable TNS

2. Why this choice? Check all
☐ Physician recommendation
☐ Lower cost
☐ Home therapy/convenience
☐ Avoid needles
☐ Avoid electrical stimulation
☐ Avoid surgery
☐ FDA-cleared treatment
☐ Travel considerations
☐ Scheduling considerations
☐ Assistance/support available
☐ Good ☐ Bad experience
☐ Tech Interest/Experiment
☐ Other: _____

3. Did you discuss treatment alternatives with a physician or healthcare professional?
☐ Yes ☐ No

4. Overall Therapy Results:
My approach worked:
☐ Better than expected
☐ About as expected
☐ Not as hoped
☐ Unsure

5. Compared with Week 1, my symptoms are:
☐ Much better
☐ Somewhat better
☐ About the same
☐ Worse

6. Symptoms Improved:
☐ Urgency ☐ Frequency
☐ Nighttime trips
☐ Leakage / Incontinence
☐ Other:_____

7. Did practical factors affect your treatment decisions?
☐ Cost
☐ Distance/travel
☐ Time/scheduling
☐ Physical dexterity
☐ Available assistance
☐ Insurance
☐ Other:_____

8. Changing Therapy
Will you continue TNS?
☐ Continue same
☐ Change TNS approach
☐ Change to non-TNS
☐ Stop therapy
☐ Unsure

9. Future Treatment Schedule:
☐ 3× weekly
☐ 2× weekly
☐ Weekly
☐ Every other Week
☐ Monthly maintenance
☐ As needed
☐ Other: _____

10. Intensity Observations
Did you increase stimulation intensity from week to week
☐ Yes ☐ No

Did you increase stimulation intensity during your treatments?
☐ Yes ☐ No

If yes, what did you observe after the change?
☐ **Symptoms improved**
☐ **Symptoms worsened**
☐ **No noticeable change**
☐ **Unsure**

We do not yet know how changes in stimulation intensity may affect TNS results. Please report what you observed:
_____

_____

11. TTNS Placement Template
Did you use the template?
☐ Yes ☐ No

If yes, will you continue using it?
☐ **Yes** ☐ **No** ☐ **Unsure**

12. Did the template help with:
☐ N/A
☐ Consistent placement
☐ Learning placement
☐ Dexterity limitations
☐ Convenience
☐ Confidence
☐ Other: _____

13. How can we improve the template? ☐ N/A

_____

14. Other observations/comments:

_____

_____

_____

_____

_____

_____

(Continue on a 2nd sheet if needed.)

Optional Contact Information (only if you permit OAB Therapy 101 to contact you about your report):