

Filling Out The Pain Report

IF YOU NEED HELP COMPLETING ANY PART OF THIS FORM, CONTACT YOUR SOCIAL SECURITY OFFICE. WE WILL HELP YOU.

The information that you give us on this form will be used by the office that makes the disability decision on this disability claim. You can help them by completing as much of the form as you can.

- Print or type.
- Do not ask a doctor or hospital to complete this form.
- When we ask for certain numbers, such as Social Security and telephone numbers, we provide blocks to fill in. In these places, please print only one number in each block.
- Be sure to explain your answer if an explanation is requested or needed.
- If more space is needed to answer any of the questions, please use the "REMARKS" section and show the number of the question being answered.

The information we ask for on this form tells us about any pain that the child has. The information includes where the pain is, how long the pain lasts, how often the pain occurs, how bad the pain is, what causes the pain, what relieves the pain and what treatment or medication makes it better.

ANYONE MAKING A FALSE STATEMENT OR REPRESENTATION OF A MATERIAL FACT FOR USE IN DETERMINING A RIGHT TO PAYMENT UNDER THE SOCIAL SECURITY ACT COMMITS A CRIME PUNISHABLE UNDER FEDERAL LAW.

**PLEASE REMOVE THIS SHEET BEFORE
RETURNING THE COMPLETED FORM.**

The Privacy And Paperwork Reduction Acts

The Social Security Administration is authorized to collect the information on this form under sections 205(a), 223(d) and 1631 (e)(1) of the Social Security Act. The information on this form is needed by Social Security to make a decision on the named claimant's claim. While giving us the information on this form is voluntary, failure to provide all or part of the requested information could prevent an accurate or timely decision on the named claimant's claim. Although the information you furnish is almost never used for any purpose other than making a determination about the claimant's disability, such information may be disclosed by the Social Security Administration as follows: (1) to enable a third party or agency to assist Social Security in establishing rights to Social Security benefits and/or coverage; (2) to comply with Federal Laws requiring the release of information from Social Security records (e.g., to the General Accounting Office and the Department of Veterans Affairs); and (3) to facilitate statistical research and such activities necessary to assure the integrity and improvement of the Social Security programs (e.g., to the Bureau of the Census and private concerns under contract to Social Security).

We may also use the information you give us when we match records by computer. Matching programs compare our records with those of other Federal, State, or local government agencies. Many agencies may use matching programs to find or prove that a person qualifies for benefits paid by the Federal government. The law allows us to do this even if you do not agree to it.

Explanations about these and other reasons why information you provide us may be used or given out are available in Social Security offices. If you want to learn more about this, contact any Social Security office.

The Paperwork Reduction Act of 1995 requires us to notify you that this information collection is in accordance with the clearance requirements of section 3507 of the Paperwork Reduction Act of 1995. We may not conduct or sponsor, and you are not required to respond to, a collection of information unless it displays a valid OMB control number.

Time It Takes To Complete This Form

We estimate that it will take you about 15 minutes to complete this form. This includes the time it will take to read the instructions, gather the necessary facts, and fill out the form. If you have comments or suggestions on this estimate, write to the Social Security Administration, ATTN: Reports Clearance Officer, 1-A-21 Operations Building, Baltimore, MD 21235-0001. **Send only comments relating to our "time it takes" estimate to the office listed above. All requests for Social Security cards and other claims-related information should be sent to your local Social Security office, whose address is listed under Social Security Administration in the U.S. Government section of your telephone directory.**

SECTION 2 - FIRST PAIN

2. A. Where does the child have the pain? *For example, chest, ear, etc.*

B. When the child is in pain, what does he or she do? *For example, cries constantly, pulls at the ear, etc.*

C. How often does he or she have the pain?

_____ per
Number of times

Minute

Day

Month

OR

Continuously

Hour

Week

Year

D. How long does the pain generally last? *Try to answer in terms of length of time he or she has pain without stopping; for example, 30 minutes, 2 hours, all day, etc.*

E. Based on what you have seen, tell us how bad the child's pain seems to be. *Be specific; describe in your own words any ways that the pain appears to stop the child from doing things other children his or her age can do. If the child has not always had pain, explain how the pain has changed the way(s) that he or she can do things.*

F. What appears to cause the pain or make it worse?

2. G. What appears to relieve the pain or make it better?

H. If the child takes any medicine(s) (prescription or non-prescription) for this pain, please complete the following:

Name of Medicine? <i>(for example, CODEINE)</i>	Date The Child Began Taking it <i>(for example, 12/06/91)</i>	Dosage <i>(for example, 1-2 pills)</i>	How Often Taken? <i>(for example, every 4 HOURS)</i>	Relieves the pain?
	Month Day Year <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>			<input type="checkbox"/> Always <input type="checkbox"/> Sometimes <input type="checkbox"/> Never
	Month Day Year <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>			<input type="checkbox"/> Always <input type="checkbox"/> Sometimes <input type="checkbox"/> Never
	Month Day Year <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>			<input type="checkbox"/> Always <input type="checkbox"/> Sometimes <input type="checkbox"/> Never

I. Does the medication cause any side effects?
If "yes," please explain:

YES NO

SECTION 3 - SECOND PAIN

3. A. Where does the child have the pain? *For example, chest, ear, etc.*

B. When the child is in pain, what does he or she do? *For example, cries constantly, pulls at the ear, etc.*

C. How often does he or she have the pain?

_____ **per**
Number of times

Minute

Day

Month

OR

Continuously

Hour

Week

Year

D. How long does the pain generally last? *Try to answer in terms of length of time he or she has pain without stopping; for example, 30 minutes, 2 hours, all day, etc.*

E. Based on what you have seen, tell us how bad the child's pain seems to be. *Be specific; describe in your own words any ways that the pain appears to stop the child from doing things other children his or her age can do. If the child has not always had pain, explain how the pain has changed the way(s) that he or she can do things.*

F. What appears to cause the pain or make it worse?

3. G. What appears to relieve the pain or make it better?

H. If the child takes any medicine(s) (prescription or non-prescription) for this pain, please complete the following:

Name of Medicine? <i>(for example, CODEINE)</i>	Date The Child Began Taking it <i>(for example, 12/06/91)</i>	Dosage <i>(for example, 1-2 pills)</i>	How Often Taken? <i>(for example, every 4 HOURS)</i>	Relieves the pain?
	Month Day Year <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>			<input type="checkbox"/> Always <input type="checkbox"/> Sometimes <input type="checkbox"/> Never
	Month Day Year <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>			<input type="checkbox"/> Always <input type="checkbox"/> Sometimes <input type="checkbox"/> Never
	Month Day Year <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>			<input type="checkbox"/> Always <input type="checkbox"/> Sometimes <input type="checkbox"/> Never

I. Does the medication cause any side effects? YES NO
If "yes," please explain:

SECTION 4 - THIRD PAIN

4. A. Where does the child have the pain? *For example, chest, ear, etc.*

B. When the child is in pain, what does he or she do? *For example, cries constantly, pulls at the ear, etc.*

C. How often does he or she have the pain?

_____ per
Number of times

Minute

Day

Month

Hour

Week

Year

OR

Continuously

D. How long does the pain generally last? *Try to answer in terms of length of time he or she has pain without stopping; for example, 30 minutes, 2 hours, all day, etc.*

E. Based on what you have seen, tell us how bad the child's pain seems to be. *Be specific; describe in your own words any ways that the pain appears to stop the child from doing things other children his or her age can do. If the child has not always had pain, explain how the pain has changed the way(s) that he or she can do things.*

F. What appears to cause the pain or make it worse?

4. G. What appears to relieve the pain or make it better?

H. If the child takes any medicine(s) (prescription or non-prescription) for this pain, please complete the following:

Name of Medicine? (for example, CODEINE)	Date The Child Began Taking it (for example, 12/06/91)	Dosage (for example, 1-2 pills)	How Often Taken? (for example, every 4 HOURS)	Relieves the pain?
	Month Day Year <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>			<input type="checkbox"/> Always <input type="checkbox"/> Sometimes <input type="checkbox"/> Never
	Month Day Year <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>			<input type="checkbox"/> Always <input type="checkbox"/> Sometimes <input type="checkbox"/> Never
	Month Day Year <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>			<input type="checkbox"/> Always <input type="checkbox"/> Sometimes <input type="checkbox"/> Never

I. Does the medication cause any side effects? YES NO
If "yes," please explain:
