Pain Report - Child

Filling Out The Pain Report

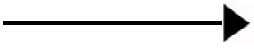
IF YOU NEED HELP COMPLETING ANY PART OF THIS FORM, CONTACT YOUR SOCIAL SECURITY OFFICE. WE WILL HELP YOU.

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.
- 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 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.

PLEASE REMOVE THIS SHEET BEFORE RETURNING THE COMPLETED FORM.

Continued on the Reverse 

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 Government Accountability 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.

PAPERWORK REDUCTION ACT: This information collection meets the requirements of 44 U.S.C. § 3507, as amended by Section 2 of the Paperwork Reduction Act of 1995. You do not need to answer these questions unless we display a valid Office of Management and Budget control number. We estimate that it will take about 15 minutes to read the instructions, gather the facts, and answer the questions. **SEND OR BRING THE COMPLETED FORM TO YOUR LOCAL SOCIAL SECURITY OFFICE. The office is listed under U. S. Government agencies in your telephone directory or you may call Social Security at 1-800-772-1213.** *You may send comments on our time estimate above to*: *SSA, 6401 Security Boulevard, Baltimore, MD 21235-6401.* ***Send only comments relating to our time estimate to this address, not the completed form.***

Form Approved
OMB No. 0960-0540

PAIN REPORT - CHILD

SECTION 1 - IDENTIFYING INFORMATION

1.

A. Print NAME OF CHILD:

FIRST	MIDDLE	LAST

B. CHILD'S SOCIAL SECURITY NUMBER:

- -

C. YOUR NAME (if you represent an agency, provide agency name):

DAYTIME TELEPHONE NUMBER *(including Area Code)***:**

( ) -

MAILING ADDRESS (Number and Street, Apt. No. (if any), P.O. Box, or Rural Route):

CITY	STATE	ZIP CODE
		-

PAIN DESCRIPTION

Please answer the questions on the following pages concerning the pain related to the child's illnesses or injuries. Answer the questions the best you can based on what the child has told you and what you have observed. If he or she has pain in more than one part of his or her body (for example, chest pain and ear pain), please describe each one separately. Use Section 2 for the first pain, Section 3 for the second pain, and so on. If he or she has pain in more than three parts of the body, use Section 5, REMARKS, to describe the other pains.

SECTION 2 - FIRST PAIN

2. A. Where does the child have 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? *(for example, CODEINE)*	**Date The Child Began Taking it** *(for example, 12/06/1991)*	**Dosage** *(for example, 1-2 pills)*	**How Often Taken?** *(for example, every 4 HOURS)*	**Relieves the pain?**
	Month/Day/Year			☐ Always ☐ Sometimes ☐ Never
	Month/Day/Year			☐ Always ☐ Sometimes ☐ Never
	Month/Day/Year			☐ Always ☐ Sometimes ☐ Never

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

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? *(for example, CODEINE)*	**Date The Child Began Taking it** *(for example, 12/06/1991)*	**Dosage** *(for example, 1-2 pills)*	**How Often Taken?** *(for example, every 4 HOURS)*	**Relieves the pain?**
	Month/Day/Year			☐ Always ☐ Sometimes ☐ Never
	Month/Day/Year			☐ Always ☐ Sometimes ☐ Never
	Month/Day/Year			☐ Always ☐ Sometimes ☐ 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

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?

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, 12/06/1991)*	**Dosage** *(for example, 1-2 pills)*	**How Often Taken?** *(for example, every 4 HOURS)*	**Relieves the pain?**
	Month/Day/Year			☐ Always ☐ Sometimes ☐ Never
	Month/Day/Year			☐ Always ☐ Sometimes ☐ Never
	Month/Day/Year			☐ Always ☐ Sometimes ☐ Never

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

SECTION 5 - REMARKS