RK1/RLH

980624300286 RK1

Department of Health & Family Services
Disability Determination Bureau
"P" (D-35)

State of Wisconsin

PAIN QUESTIONNAIRE

Claimant's Name: DIB INITIAL
Social Security No: 394-73-5555

Please answer the following questions. Try to be specific and give examples.

1. When did you begin having pain? (Approximate date, event, activity)

2. How has your pain changed since then?

3. Describe your activities which cause pain.

4. When do you have pain?

5. What medications do you take to reduce pain? (How often, how much)

6. Besides taking medication, how do you reduce the pain?

7. How long does it take to reduce the pain?

8. Describe your sleeping patterns (how long, naps, how often)

9. Has pain changed any of your activities? Please describe.

Please give us the name, address, and phone number of someone (social worker, friend, family member or neighbor) who could provide additional information regarding your daily activities.

Name: _____

Address: _____

Phone Number: _____

Upon completion of the questions, please sign and date below.

Signature _____ Date_____

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ATTACHMENTS