
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.**

PRIVACY ACT STATEMENT

Collection and Use of Personal Information

Sections 1614(a)(3)(H)(i), 1631(d)(1), and 1631(e)(1) of the Social Security Act, as amended, allow us to collect this information. We will use the information you provide to make a decision on the named individual's disability claim.

Furnishing us this information is voluntary. However, failing to provide all or part of the information may prevent us from making an accurate and timely decision on the named individual's claim.

We rarely use the information you supply for any purpose other than what we state above, however, we may use the information for the administration of our programs, including sharing information:

1. To comply with Federal laws requiring the release of information from our records (e.g., to the Government Accountability Office and Department of Veterans Affairs); and,
2. To facilitate statistical research, audit, or investigative activities necessary to ensure the integrity and improvement of our programs (e.g., to the Bureau of the Census and to private entities under contract with us).

A list of when we may share your information with others, called routine uses, is available in our Privacy Act System of Records Notices, 60-0089, entitled Claims Folder System, and 60-0103, entitled Supplemental Security Income and Special Veterans Benefits. Additional information about these and other system of records notices and our programs are available from our Internet website at www.socialsecurity.gov or at your local Social Security office.

We may also use the information you provide in computer matching programs. Matching programs compare our records with records kept by other Federal, State, or local government agencies. Information from these matching programs can be used to establish or verify a person's eligibility for federally funded or administered benefit programs and for repayment of incorrect payments or delinquent debts under these programs.

Paperwork Reduction Act Statement

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 (OMB) control number. We estimate that it will take about 15 minutes to read the instructions, gather the facts, and answer the questions. **Send only comments relating to our time estimate above to:** SSA, 6401 Security Blvd, Baltimore, MD 21235-6401.

Pain Report - Child

SECTION 1 - IDENTIFYING INFORMATION

1A. Print Name of Child First	Middle	Last
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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
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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

2A. 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? Number of times

per 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?

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, 12/06/1991)</i>	Dosage <i>(for example, 1-2 pills)</i>	How Often Taken? <i>(for example, every 4 hours)</i>	Relieves the pain?
				<input type="checkbox"/> Always <input type="checkbox"/> Sometimes <input type="checkbox"/> Never
				<input type="checkbox"/> Always <input type="checkbox"/> Sometimes <input type="checkbox"/> Never
				<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 3 -SECOND PAIN

3A. 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? Number of times

per 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?

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, 12/06/1991)</i>	Dosage <i>(for example, 1-2 pills)</i>	How Often Taken? <i>(for example, every 4 hours)</i>	Relieves the pain?
				<input type="checkbox"/> Always <input type="checkbox"/> Sometimes <input type="checkbox"/> Never
				<input type="checkbox"/> Always <input type="checkbox"/> Sometimes <input type="checkbox"/> Never
				<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

4A. 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? Number of times

per 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?

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, 12/06/1991)</i>	Dosage <i>(for example, 1-2 pills)</i>	How Often Taken? <i>(for example, every 4 hours)</i>	Relieves the pain?
				<input type="checkbox"/> Always <input type="checkbox"/> Sometimes <input type="checkbox"/> Never
				<input type="checkbox"/> Always <input type="checkbox"/> Sometimes <input type="checkbox"/> Never
				<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 5 - REMARKS
