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 and 1631 of the Social Security Act, as amended, allows us to collect this information. Furnishing us this information is voluntary. However, failing to provide all or part of the information may prevent an accurate and timely decision on our determination of eligibility for and the amount of Supplemental Security Income (SSI) benefits for a child who is claiming a disability.

We will use the information to determine a child's eligibility for SSI benefits. We may also share the child's disability information for the following purposes, called routine uses:

- Information may be disclosed to contractors and other Federal agencies, as necessary, for the purpose of assisting SSA in the efficient administration of its programs. We contemplate disclosing information under this routine use only in situations in which SSA may enter a contractual or similar agreement with a third party to assist in accomplishing an agency function relating to this system of records; and

- To State agencies to enable them to assist in the effective and efficient administration of the Supplemental Security Income program.

In addition, we may share this information in accordance with the Privacy Act and other Federal laws. For example, where authorized, we may use and disclose this information in computer matching programs, in which our records are compared with other records to establish or verify a person's eligibility for Federal benefit programs and for repayment of incorrect or delinquent debts under these programs.

A list of additional routine uses is available in two of our Privacy Act System of Records Notices (SORN) 60-0089, entitled Claims Folders Systems, as published in the Federal Register (FR) on April 1, 2003, at 68 FR 15784 and 60-0103, entitled Supplemental Security Income Record and Special Veterans Benefits as published in the FR on January 11, 2006, at 71 FR 1830. Additional information, and a full listing of all of our SORNs, is available on our website at www.ssa.gov/privacy.

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 regarding this burden estimate or any other aspect of this collection, including suggestions for reducing this burden to*****:** *SSA, 6401 Security Blvd, Baltimore, MD 21235-6401.*

Pain Report - Child

SECTION 1 - IDENTIFYING INFORMATION

1A. 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

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? *(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?**
				☐ Always ☐ Sometimes ☐ Never
				☐ Always ☐ Sometimes ☐ Never
				☐ Always ☐ Sometimes ☐ 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? *(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?**
				☐ Always ☐ Sometimes ☐ Never
				☐ Always ☐ Sometimes ☐ Never
				☐ Always ☐ Sometimes ☐ 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? *(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?**
				☐ Always ☐ Sometimes ☐ Never
				☐ Always ☐ Sometimes ☐ Never
				☐ Always ☐ Sometimes ☐ Never

I. Does the medication cause any side effects? ☐ Yes ☐ No

*If "**yes**," please explain:*

SECTION 5 - REMARKS