(Y) Casenbr:

FOR SOCIAL SECURITY ADMINISTRATION
S71 DISABILITY DETERMINATIONS
PO BOX 8754
LONDON KY 40742-9826

FAX RESPONSE TO:
RETURN THE COMPLETED FORM IN THE ENCLOSED BUSINESS REPLY ENVELOPE
PLEASE DO NOT MAIL IF YOU FAX YOUR RESPONSE
THIS PAGE MUST BE ON TOP OF YOUR RESPONSE, PLEASE DO NOT USE ANY OTHER FAX COVER SHEET

This office is responsible for developing evidence in connection with your Social Security disability claim. In order for us to fully understand your condition, we need some more information. Please complete this questionnaire, WHICH BEGINS BELOW, in as much detail as you can, and sign and date the form. Please complete the form in English. Fax the form to the number above, or mail the form to us in the enclosed business reply envelope within ten days.

If we do not hear from you within ten days from the date of this letter, your claim may be unnecessarily delayed or a decision may be made on your claim based on the information currently in your file. Because we are missing some important information, this could result in a finding that you are not eligible for disability benefits.

SUPPLEMENTAL PAIN QUESTIONNAIRE

1. Please describe your pain symptoms. Try to be as specific as possible regarding the type of pain, location/radiation of pain, and intensity/severity of the pain, etc.

2. What factors cause you to experience pain? (For example, specific activities such as bending, standing, walking, sitting, reaching, temperature extremes, etc.) Please provide specific examples.

CC: ASSOCIATES AND AVARD LAW OFFICES

Florida Department of Health
FOR SOCIAL SECURITY ADMINISTRATION
S71 DISABILITY DETERMINATIONS
PO BOX 8754
LONDON KY 40742-9826

CASENBR:

PLEASE BE SURE YOU ANSWER THE QUESTIONS ON THE FIRST, BARCODED PAGE.

3. How frequently do you experience pain and how long does your pain usually last?

4. What relieves your pain?

5. What prescription or non-prescription medication do you take for relief of pain?

6. How effective are these medications in relieving your pain? Please discuss.

7. Please describe any side effects from your medication.

8. Besides medication, have you tried other forms of therapy or treatment for relief of your pain? (For example, physical therapy TENS unit, biofeedback, etc.) Please explain.

9. Please describe how your condition affects the following areas. Provide specific examples if possible.

   Cooking/meal preparation-

   Personal care (bathing, hair care, dressing)-

   Housecleaning-

   Laundry-

   Shopping-

   Sleeping-

CASENBR:

Driving-

Yard work, gardening-

Social activities/hobbies-

Child care-

Home maintenance-

Sitting-

Standing-

Walking-

10. Please provide any additional comments regarding how your condition limits your ability to work. Please attach additional pages if you need more space.

PLEASE BE SURE YOU ANSWER THE QUESTIONS ON THE FIRST, BARCODED PAGE.

In case we need to contact you, please provide a telephone number where you can be reached and the best time of the day for us to call.

Telephone Number: _____ Time of day: _____

Signature: _____ Date: _____

If you have any questions, please call me between the hours of 9:00 AM and 4:00 PM, Monday through Friday. We appreciate your help in giving us this information.

Sincerely,

Medical Disability Adjudicator

This letter contains information that is confidential under federal and state statutes and is intended to be delivered to only the named addressee. Any unauthorized use of this information may be a violation of criminal statutes. If you received this letter in error, you should immediately notify this agency at the address above or the telephone number below. We will provide you with instructions regarding the disposal of this letter. Under no circumstances should this information be shared, retained, or copied by anyone other than the named addressees.