RESTORATION ORTHOPAEDICS
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Dr. Julie M. Keller ☐ **Dr. Stephen R. Lindholm** ☐ **Dr. Jesse W. Allert** ☐

Purpose of Your Visit

What is the condition for which you are seeking medical attention? _____

_____

Was injury/pain a result of an accident? Yes ☐ No ☐

If yes: Job Related: ____Auto:____ Other:_____

Date of injury or onset: _____/_____/_____

Describe the events of the injury/accident/pain:_____

_____

_____

Have you previously been treated for this or a similar condition? If yes, what was the treatment?

_____

_____

What were the results of the treatment? : _____

_____

_____

Have you had any diagnostic test related to condition (i.e. X-ray, MRI, CT, EMG)? If yes, please list.

No ( ) Yes ( )_____

(Please give any reports/results of testing to receptionist)

Is there any other information you would like to share regarding your condition?_____

_____

Signature:_____

Date:_____