



# AppletonClinics™

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## ***New Patient Questionnaire***

*Please print clearly*

Patient Name: \_\_\_\_\_ Male \_\_\_\_\_ Female \_\_\_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_

Home Phone #: \_\_\_\_\_ Cell #: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Previous Physician: \_\_\_\_\_

Reason for leaving that practice: \_\_\_\_\_

Have you ever been to Appleton Clinics as a patient? YES or NO

Current & Past Medical Problems: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Current Medications (Please List All): \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

How soon do you need to be seen? \_\_\_\_\_

Employer: \_\_\_\_\_

Are any of your relatives patients of Appleton Clinics? YES or NO

Who? \_\_\_\_\_

How did you hear about us? \_\_\_\_\_