Holt Homeopathy 2024-2025

EricaHolt.Com

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Homeopathic Consultation Form

Name:_____
Date of Birth: D_____ M_____ Y_____ Marital Status: M_____S_____Divorced____Widowed____

Address:_____

City_____State_____Zip Code:_____

Telephone: Home:_____ Work_____

Other_____ E-mail_____
Referred By:_____Present M.D. and Phone.:_____

Blood Type:_____

Weight_____ Height_____

Number of children:_____ Number of pregnancies:_____

Last time you had a fever?_____

Please list your vaccinations:

Measles: Age vaccinated_____ reaction:_____

Mumps: Age vaccinated_____ reaction:_____

Chicken Pox: Age Vac_____ reaction:_____

Whooping Cough_____ reaction:_____

Pneumonia _____ reaction:_____

Covid:_____Dates:_____ reaction:_____

Boosters:_____Dates:_____ reaction:_____

Other:_____Dates:_____ reaction:_____

Additional Vaccinations/Shots:

_____

_____

Major Complaints in Order of Importance For You:

COMPLAINT	SINCE (DATE)	CAUSE

Which Medications Are You Currently Taking?

MEDICATION	SINCE	DOSE	ADVERSE REACTION

Effects What Other Treatments or Regimes Are You Currently Following?

TREATMENT	SINCE	RESULTS

Results Which of The Following Conditions Have You Had?

Abscesses, Alcoholism, Allergies, Amnesia Anemia, Arthritis , Asthma, Cancer Chicken Pox Cold Sores Colitis Covid Depression Diabetes Emphysema Epilepsy Gall Stones Goiter Gonorrhea Gout Hay-Fever Disease Hepatitis Herpes Influenza Kidney Disease Leukemia Malaria Measles Miscarriage Mononucleosis Mumps Parasites Pelvic Inflammatory Disease PCOS Pleurisy Pneumonia Prostatitis Rheumatic Fever Rubella Scarlet Fever Sexual Abuse Skin Disease Strep Throat Sinusitis Stroke Sun- Stroke Thyroid issues Tonsillitis Tuberculosis Warts Whooping Cough Worms Yellow Fever

Any Other Major Conditions/Concerns?

_____
_____
_____
_____
_____

Are there any of the preceding conditions after which you have not been totally well again?

Which ones?_____
_____
_ _____

(Women)Age of first Menses:_____ (Women)Number Pregnancies:_____
Are You Currently Under the Care of a Physician(s)? Physician For Which Condition? Treatments

_____ _____
_____ _____

What Major Operations Have You Had? Operation When Complications What Major Injuries Have You Had? Injury When Complications _____
_____
_____
_____

How Much of the Following Substances Are You Using?
Tobacco_____Alcohol_____Coffee_____Recreational Drugs_____

Indicate/circle below, which of the following ailments, or any other major ailments, have affected your relatives:

Alcoholism Allergies Arthritis Asthma Cancer Depression Diabetes

Epilepsy Gonorrhea Gout Heart Insanity Paralysis Pneumonia Skin Disease Syphilis Tuberculosis

Is there any other information that I would need to know?

Relative	**Age if alive**	**Age at Death?**	**Ailments**
Mother			
Father			
Brothers			
Sisters			
Children			
Maternal Grandmother			
Maternal Grandfather			
Paternal Grandmother			
Relative	**Age if alive**	**Age at Death**	**Ailments**
Paternal Grandfather			
Maternal Aunts			
Maternal Uncles			
Paternal Aunts			
Paternal Uncles			

Medical/Professional Waiver PLEASE READ THE FOLLOWING CAREFULLY (if under 19 years of age, a parent or guardian must sign.) I, the undersigned, understand that Erica Holt is a homeopath and not a licensed medical doctor. As such, I acknowledge that it is my responsibility to seek medical diagnosis and advice for my present and future conditions. In consulting with Erica Holt, I am exercising my right to choose an alternative method of treatment through which to address my total health. As homeopathy is not covered by the existing government medical insurance plan, I agree to pay all fees presented in the current rate schedule. I agree that “symptoms” from my consultations may be used for homeopathic teaching purposes. I acknowledge that all personal information will be kept confidential. I consent that from time to time I may receive e-mails or text messages from Erica Holt and/or Holt Homeopathy which will provide me with relevant health information/newsletter,

upcoming events, homeopathic and natural health seminars and learning opportunities. I understand that I can unsubscribe to these e-mails at any time.

Patient
Signature:_____ Date:_____

CREDIT CARD AUTHORIZATION FORM

I, _____, hereby authorize Erica Holt (DBA Holt Homeopathy LLC) to store credit card for future services.
This payment storage agreement will be in effect immediately or until ended by request of the client either verbally or in writing.

CREDIT CARD INFORMATION:

CARD TYPE: _____ VISA _____ MASTERCARD

Card Number:	_____
Card Verification Code:	_____
Expiration Date:	_____
Name on Card:	_____
Billing Street Address:	_____
City, State, Zip:	_____