DivineInterventions

Patient/Client Information

Our **first** concern at Divine Interventions is patient safety. Please fill out this form to ensure that any medical conditions, medications, nutritional supplements or anything you feel important to disclose is reported BEFORE treatment. Some treatments, medications and conditions may cause adverse reactions, resulting in complications or unintentional injury. If you have been tanning or have recently traveled to a sunny destination, it is extremely important for you to let us know. Thank you.

Personal History:

Name: _____ Today's Date: _____

Address: _____

Date of birth: _____ Alberta Health Care#: _____

Home#: _____ Cell#: _____

Occupation: _____ Email: _____

How or /where did you find out about us? (Please check):

- ☐ Google
- ☐ Facebook
- ☐ Other (please list)
- ☐ Elevator AD
- ☐ Instagram
- ☐ Referred by (please list)

_____ _____

Please indicate what you have come to talk to us about, or anything that concerns you (Please check):

- ☐ Stretch Marks
- ☐ Wrinkles
- ☐ Hollow Under eyes
- ☐ Dryness
- ☐ Brown Spots
- ☐ Droopy Eyelids
- ☐ Cystic Acne
- ☐ Oily Skin
- ☐ Broken Capillaries
- ☐ Thin Lips
- ☐ Enlarged Pores
- ☐ Uneven Skin
- ☐ Milia
- ☐ Bridged Nose
- ☐ Headaches
- ☐ Excess Sweating
- ☐ Skin Tags
- ☐ Frown Lines
- ☐ Freckles
- ☐ Moles
- ☐ Melasma
- ☐ Unwanted Hair
- ☐ Scars
- ☐ Uneven Jawline
- ☐ Rosacea
- ☐ Urinary Incontinence
- ☐ Acne
- ☐ Skin laxity
- ☐ Body Treatments

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If your concern is not listed, please give a short description of what your concern is:

_____

_____

_____

_____

_____

Medical History:

Are you currently on any medication(s)? ○ Yes ○ No

If YES, please list

_____

Do you have any allergies? ○ Yes ○ No

If YES, please list

_____

Are you currently under the care of a physician? ○ Yes ○ No

If YES, please list what for

_____

Do you suffer from any of the following conditions?

- ☐ Epilepsy
- ☐ TMJ
- ☐ Photosensitivity
- ☐ Auto-Immune Disease
- ☐ Arthritis
- ☐ Cancer
- ☐ Blood Disorders/Clotting
- ☐ Hyper-Hydrosis
- ☐ Polycystic Ovaries (PCOS)
- ☐ Keloid Scars
- ☐ Diabetes
- ☐ Herpes
- ☐ Hormonal Imbalances
- ☐ Cold Sores
- ☐ Hyper/Hypo Pigmentation
- ☐ HIV/AIDS
- ☐ Cardiac Diseases
- ☐ Psoriasis
- ☐ Acne
- ☐ Hepatitis
- ☐ Multiple Sclerosis
- ☐ Lumps/Cysts
- ☐ Migraines
- ☐ Other:

Do you have any metal implants? ○ Yes ○ No

If YES, please list

_____

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Do you smoke? ○ Yes ○ No

Skin Care History:

Are you currently under the care of a dermatologist? ○ Yes ○ No
If YES, please list what for _____

Are you currently using topical creams or skin care products? ○ Yes ○ No
If YES, please list _____

How often do you wear sunscreen? ○ Frequently ○ Occasionally ○ Rarely ○ Never

How often do you use tanning beds? ○ Frequently ○ Occasionally ○ Rarely ○ Never

Do you burn from sun exposure? ○ Frequently ○ Occasionally ○ Rarely ○ Never

Which of the following best describes your skin? (Please check):

☐ Very oily, large pores
☐ Oily
☐ Dry
☐ Combination, oily in some spots and dry in some spots
☐ Sensitive (reactive to certain products)

Do you have a tan or have you been to a sunny* location within the last 4 weeks?

○ Yes ○ No

For Female Clients Only:

Are you pregnant or trying to get pregnant? ○ Yes ○ No

Are you breastfeeding? ○ Yes ○ No

Emergency Contact

Please Provide us with an Emergency Contact:

Name: _____

Phone Number: _____

Relationship to you: _____

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Disclosure and Informed Consent

Is there anything that you feel that we should know that may affect your treatments? Please list anything you feel would help us in our ability to deliver safe and effective treatments to you:

_____

_____

_____

It is your duty to inform us of any changes is skin condition(s), sun exposure, medical diagnoses, medications, and change in any supplements you take. It is also your responsibility to inform us of any adverse reactions, abnormalities or anything unexpected as a directed or suspected result from your treatment(s) received from Divine Interventions. We are here to help.

BY MY SIGNATURE BELOW, I ACKNOWLEDGE THAT I HAVE READ AND FULLY UNDERSTAND THE CONTENTS AND PURPOSE OF THIS INFORMATION PROVIDED IN THIS DOCUMENT. I GIVE MY CONSENT TO THE STAFF OF DIVINE INTERVENTIONS TO USE THIS INFORMATION TO PERFORM MY TREATMENTS AT DIVINE INTERVENTIONS. I UNDERSTAND THAT ANY CHANGES TO THIS INFORMATION WILL BE MY SOLE RESPONSIBILITY TO REPORT TO DIVINE INTERVENTIONS.
IF I FAIL TO REPORT OR RELEASE INFORMATION REGARDING MY HEALTH, SUN EXPOSURE AND ANY OTHER CHANGES IN MY INFORMATION, AS WELL AS A TREATMENT RESULTING IN AN ADVERSE OR ANY UNFORESEEN INJURY, I RELEASE ANY LIABILITY FROM THE SERVICE PROVIDER AND FROM DIVINE INTERVENTIONS.

_____

Patient Name (Printed)

_____ _____

Patient Signature Date

_____

Staff Witness Name (Printed)

_____ _____

Staff Witness Signature Date

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Our No-Show and Cancelation Policy

Cancelling an Appointment:

Please contact us via telephone at (780) 439-1208 or email info@divineinterventions.ca at least **24 hours** prior to your scheduled appointment date and time.
Failure to provide 24 hours notice for cancelling will result in a fee of **$50.00** being charged to your credit card on file.

A *no-show* is considered failure to cancel or failure to show for a scheduled appointment and will also result in a fee of $50.00 being charged to your credit card on file.
If we currently do not have your credit card number on file and you cancel your appointment with less than 24 hours notice or you no-show to your appointment, you will be required to provide us with a credit card number before you will be welcomed to book with us again.

Reoccurring (more than 3 times) cancelations with less than 24 hours notice and/or no-shows, you will be charged the full deposit amount of half (50%) of the entire session cost.
If you have prepaid for package deal and cancel with less than 24 hours or no-show to your scheduled appointment(s), we have the right to deduct the cancellation fee from the package balance and you must pay the balance to continue treatment.

We reserve the right to refuse appointments to any client who has demonstrated disregard of our cancellation policy.

CLIENT CONSENT:
By signing below, I confirm that I understand the no-show and cancellation policy of Divine Interventions and agree to its terms.

Client Name

Client Signature

Date

Staff Witness Name

Staff Witness Signature

Date