

DAVID DELANEY, M.A., C.A.R., L.M.T., L.P.C.
CERTIFIED ADVANCED ROLFER® SINCE 1985
Licensed Professional Counselor

MAILING: P.O. Box 84, BOULDER, CO. 80306
DENVER OFFICE: 4340 EAST KENTUCKY, DENVER, CO SUITE 445
BOULDER OFFICE: 5717 ARAPAHOE, BOULDER, CO., SUITE # 8
email: david@daviddelaney-rolfing.com
www.daviddelaney-rolfing.com

303-815-3160 DIRECT 303-449-2004 VM

Today's Date _____ Date of Birth _____

Name _____

Address _____ apt _____

City _____ State _____ Zip _____

Home Phone _____ Work Phone _____
Cell Phone _____ e-mail _____

Fax _____

Referred by _____

List reasons for making appointment _____
Do you have/have you had: (if yes, circle)

Heart Condition	Hemophilia	Epilepsy	Cancer	Thyroid Condition	Migraines
Arthritis	Diabetes	Gallstones	Convulsions	Osteoarthritis	Ulcers
Phlebitis	High Blood Pressure	Low B/P	Stroke		Kidney problems
	Height		Weight		

Any major surgery(s) _____
Medications in the last 6 months? _____
What chronic bodily discomfort, if any, are you aware of? _____

Contact lenses? _____ Dentures / Removeable bridges? _____

Women: IUD? _____ Are you pregnant? _____

Are you being treated for a medical condition? _____

Who is the treating physician? _____

Do you want me to consult with your physician _____

Application and Consent for Rolfing®

I hereby apply for Rolfing Structural Integration Session(s).

I fully understand the purpose of Rolfing is to balance and align the physical. This is done through direct physical manipulation and education so that greater economy and freedom of body movement is achieved.

I understand that Rolfing is not involved with the treatment of disease of any kind, nor does it substitute for medical diagnosis or treatment when such treatment is needed.

David Delaney, Certified Advanced Rolfer, does not treat, prescribe, or diagnose any illness, disease, or any other physical or mental disorder of the person. Nothing said or done by David should be misconstrued to be such.

I understand that it is necessary for David to touch my body in order to assist me in establishing balance, freedom, and alignment in my body.

I give David my permission and consent to do all things necessary in helping me establish balance and alignment, including, but not limited to, touching my body. I give full privilege and license to work in my body in such a way as to restore and establish balance and alignment therein.

I understand that I am responsible for paying for the session if I give less than a **full 24 hours** cancellation notice. If I need to cancel or re-schedule an appointment, I will call **303-815-3160**.

_____ Initial

••24-hour cancellation policy. If you cancel with less than 24 hours before the start of your session, I ask you to be financially responsible for the session. This means you need to call *before* 24 hours before the start of the session, not the “night before”, and it means the reason is not a consideration. This policy’s sole and crucial purpose is to ensure our relationship remains clear and amicable throughout your sessions. While I can—and do—personally empathize with you over issues that can arise, please consider your booking like a concert ticket. Feel free to use it or not, as supports your best interests at the time. Double sessions require 48 hours notice for the first session and 24 hours as usual for the second.

If I am late or there is an emergency at the time of the appointment, I will call **303-815-3160** to notify of such occurrence, if I am at all able.

I understand that there is a \$25 service charge for all returned checks.

I understand that I am an active participant in these sessions and that I am responsible for making my needs and preferences known to my therapist.

_____ Date _____

Client Signature

_____ Print Name