

JANIS LUBY'S  
**SCULPT**

2609 BROADWAY, EVANSTON  
847-894-1453

### Health History Form

Name \_\_\_\_\_ Date \_\_\_\_\_

Address \_\_\_\_\_

Home phone \_\_\_\_\_ Work phone \_\_\_\_\_

Gender      male \_\_\_\_\_ female \_\_\_\_\_

Age \_\_\_\_\_ Birth date \_\_\_\_\_ Weight \_\_\_\_\_ Height \_\_\_\_\_

Occupation \_\_\_\_\_

Physician's name \_\_\_\_\_ Physician's phone \_\_\_\_\_

Does your physician know that you are participating in an exercise/fitness program? \_\_\_\_\_

Date of last physical examination \_\_\_\_\_

Are you taking any medications?

no \_\_\_\_\_ yes \_\_\_\_\_ (Please list medications and reasons for usage below.)

Medication

Reason for usage

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Are you taking any vitamins or dietary supplements?

no \_\_\_\_\_ yes \_\_\_\_\_ (Please list supplements and reasons for usage below.)

Medication

Reason for usage

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Do you now, or have you had in the past:	yes	no
1. History of heart problems, chest pain or stroke?	___	___
2. Increased blood pressure?	___	___
3. Any chronic illness or condition?	___	___
4. Do you ever get dizzy, lose your balance or lose consciousness?	___	___
5. Difficulty with physical exercise?	___	___
6. Advice from physician not to exercise?	___	___
7. Recent surgery (last 12 months)?	___	___
8. Pregnancy (now or within last 3 months)?	___	___
9. History of breathing or lung problems?	___	___
10. Swollen, stiff, or painful joints?	___	___
11. Foot problems?	___	___
12. Back problems?	___	___
13. Any significant vision or hearing problems?	___	___
14. Diabetes or thyroid condition?	___	___
15. Cigarette smoking habit?	___	___
16. Do you ever drink alcoholic beverages?	___	___
17. Increased blood cholesterol?	___	___
18. History of heart problems in immediate family?	___	___
19. Hernia or a condition that may be aggravated by lifting weights?	___	___
20. Do you have asthma?	___	___

Please explain any yes answers below:

Do you have any other medical conditions or problems not previously mentioned? If so, please explain.

## Family History Form

**Father**

Current age \_\_\_\_\_

Father's general health is:      excellent \_\_\_ good \_\_\_ fair \_\_\_ poor \_\_\_

Reason for fair/poor health is?

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### **Mother**

Current age \_\_\_\_\_

Mother's general health is:      excellent \_\_\_ good \_\_\_ fair \_\_\_ poor \_\_\_

Reason for fair/poor health is?

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### **Siblings**

Number of brothers \_\_\_\_\_ Number of sisters \_\_\_\_\_ Age range \_\_\_\_\_

Any health problems? Please explain.

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**Have any of your BLOOD relatives had:**                      yes                      no

- |                                     |     |     |
|-------------------------------------|-----|-----|
| 1. Heart attack under age 50?       | ___ | ___ |
| 2. Stroke under age 50?             | ___ | ___ |
| 3. High blood pressure?             | ___ | ___ |
| 4. Elevated cholesterol?            | ___ | ___ |
| 5. Diabetes?                        | ___ | ___ |
| 6. Asthma or hay fever?             | ___ | ___ |
| 7. Heart operations?                | ___ | ___ |
| 8. Obesity?                         | ___ | ___ |
| 9. Leukemia or cancer under age 60? | ___ | ___ |

### **Comments**

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## **Goals**

Cardio-respiratory endurance, Muscular Strength & Endurance, Flexibility, Body Composition & Nutrition. Long term goals:

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

Short term objectives:

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

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## Terms of Training

- I understand that all sessions must be pre-paid.
- I am aware that it is my responsibility to attend all scheduled appointments. If I need to cancel or reschedule, I must give 24 hour notice or I will be billed for the missed session.
- I agree to use my 5 or 10 sessions within a six (6) month time period. I understand that after six (6) months my sessions will expire and that I will lose any remaining sessions.
- I understand that all training sessions that I purchase are non-refundable.
- I understand the personal training price structure and agree to all the aforementioned policies.

**Client Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

At Sculpt, we strongly recommend that all participants in our exercise programs consult their physician prior to participation.

I acknowledge, to the best of my ability, that I am in good health and have no known medical problems that would restrict my ability to participate in this exercise program.

**Client Signature** \_\_\_\_\_ **Date** \_\_\_\_\_