

FORM 1 | ABOUT YOU

DATE COMPLETED ____|____|____

FIRST NAME	LAST NAME	EMPLOYEE ID #
DATE OF BIRTH	GENDER (CIRCLE ONE) M F	WORK EMAIL
COMPANY	FLOOR	WORK PHONE
PRIMARY PHYSICIAN	PHYSICIAN PHONE	PHYSICIAN FAX
EMERGENCY CONTACT NAME	EMERGENCY CONTACT PHONE	RELATIONSHIP

EMPLOYMENT STATUS Full-time Temporary Consultant Intern

HOW DID YOU HEAR ABOUT REVISIONS? _____

ACTIVITY AND HEALTH LEVEL

How many days a week do you usually get 30 minutes or more of exercise/physical activity?

- None 2 days 4 days 6 days
 1 day 3 days 5 days 7 days

How intense is your activity: Easy Moderate Difficult

How would you rate your current level of health?

- Poor Fair Good Excellent

How would you rate your current level of stress?

- Very High (8-10) High (6-7) Medium (3-5) Low (1-2)

HEALTH AND WELLNESS INTERESTS

Please check the topics you are interesting in learning more about:

- | | | | |
|--|---|---|---|
| <input type="checkbox"/> Aging | <input type="checkbox"/> Ergonomics | <input type="checkbox"/> Metabolic Testing | <input type="checkbox"/> Skin Care |
| <input type="checkbox"/> Alternative Health | <input type="checkbox"/> Flexibility | <input type="checkbox"/> Nutrition | <input type="checkbox"/> Sleep Management |
| <input type="checkbox"/> Back Care | <input type="checkbox"/> Food Safety | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Smoking Cessation |
| <input type="checkbox"/> Children's Health | <input type="checkbox"/> Group Exercise Classes | <input type="checkbox"/> Parenting | <input type="checkbox"/> Specialty Classes |
| <input type="checkbox"/> Communication Skills | <input type="checkbox"/> Health Screening | <input type="checkbox"/> Personal Training | <input type="checkbox"/> Sports Injury Prevention |
| <input type="checkbox"/> Cooking Classes | <input type="checkbox"/> Heart Health | <input type="checkbox"/> Prevention | <input type="checkbox"/> Stress Management |
| <input type="checkbox"/> CPR/ First Aid Training | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Pre- Natal Health | <input type="checkbox"/> Substance Abuse |
| <input type="checkbox"/> Crime Prevention | <input type="checkbox"/> HIV/ AIDS | <input type="checkbox"/> Post- Natal Health | <input type="checkbox"/> Weight Management |
| <input type="checkbox"/> Disease Prevention | <input type="checkbox"/> Menopause | <input type="checkbox"/> Safety | <input type="checkbox"/> Women's Health |
| <input type="checkbox"/> Eating Disorders | <input type="checkbox"/> Men's Health | <input type="checkbox"/> Self Defense | <input type="checkbox"/> Other |



FORM 3 | HEALTH HISTORY QUESTIONNAIRE

FIRST NAME	LAST NAME	EMPLOYEE ID #
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BOX 1: DO YOU HAVE A HISTORY OF ANY OF THE FOLLOWING CARDIAC, METABOLIC, OR PULMONARY CONDITIONS? MARK ALL THAT APPLY.

CARDIAC/VASCULAR Diagnosed high blood pressure <input type="checkbox"/> Yes <input type="checkbox"/> No <small>(systolic BP>140 or diastolic BP>90mmHG on at least two separate checks)</small> Coronary angioplasty or cardiac surgery..... <input type="checkbox"/> Yes <input type="checkbox"/> No Heart disease, heart attack, angina <input type="checkbox"/> Yes <input type="checkbox"/> No Heart murmur <input type="checkbox"/> Yes <input type="checkbox"/> No Peripheral vascular disease..... <input type="checkbox"/> Yes <input type="checkbox"/> No Stroke <input type="checkbox"/> Yes <input type="checkbox"/> No Other: <input type="checkbox"/> Yes <input type="checkbox"/> No	METABOLIC Diabetes..... <input type="checkbox"/> Yes <input type="checkbox"/> No Kidney disease <input type="checkbox"/> Yes <input type="checkbox"/> No Thyroid or other metabolic disorders..... <input type="checkbox"/> Yes <input type="checkbox"/> No RESPIRATORY Asthma..... <input type="checkbox"/> Yes <input type="checkbox"/> No Chronic bronchitis..... <input type="checkbox"/> Yes <input type="checkbox"/> No Emphysema or chronic obstructive pulmonary disease (COPD)..... <input type="checkbox"/> Yes <input type="checkbox"/> No Other: <input type="checkbox"/> Yes <input type="checkbox"/> No
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BOX 2: DO YOU CURRENTLY HAVE ANY OF THE FOLLOWING SIGNS, SYMPTOMS, OR CONDITIONS? MARK ALL THAT APPLY.

Ankle swelling <input type="checkbox"/> Yes <input type="checkbox"/> No Chest pain (at rest or exertion) <input type="checkbox"/> Yes <input type="checkbox"/> No Dizziness/fainting <input type="checkbox"/> Yes <input type="checkbox"/> No WOMEN: Are you pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No	Rapid heartbeats or palpitations..... <input type="checkbox"/> Yes <input type="checkbox"/> No Shortness of breath (at mild exertion/rest)..... <input type="checkbox"/> Yes <input type="checkbox"/> No Unexplained fatigue (unusual fatigue or shortness of breath with usual activities) <input type="checkbox"/> Yes <input type="checkbox"/> No
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If you marked "yes" to one or more of the items in Box 1 or 2, you must obtain your personal physician's consent prior to scheduling your new member appointments. See Medical Consultation Form.

BOX 3: DO YOU CURRENTLY HAVE ANY OF THE FOLLOWING CORONARY RISK FACTORS?

Female, age 55 or older <input type="checkbox"/> Yes <input type="checkbox"/> No Male, age 45 or older <input type="checkbox"/> Yes <input type="checkbox"/> No Hypercholesterolemia, elevated cholesterol, abnormal blood lipids (total cholesterol>200mg/dL or HDL<mg/dL) <input type="checkbox"/> Yes <input type="checkbox"/> No	Smoking habit (within past six months)..... <input type="checkbox"/> Yes <input type="checkbox"/> No Family history of heart disease (parents/siblings before age 55)..... <input type="checkbox"/> Yes <input type="checkbox"/> No Sedentary lifestyle (inactive job with no regular exercise program; active less than 3 times per week; or no recreational pursuits) <input type="checkbox"/> Yes <input type="checkbox"/> No
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If you marked "yes" to two or more of the items in Box 3, you must obtain your personal physician's consent prior to scheduling your new member appointments. See Medical Consultation Form.

PLEASE INDICATE IF YOU HAVE ANY OF THE FOLLOWING CONDITIONS. THESE CONDITIONS MAY REQUIRE A MEDICAL CONSULTATION.

Major surgery or hospitalization within the past six months. Please explain:

<input type="checkbox"/> Anemia (severe<10GM/dL)	<input type="checkbox"/> Allergies (please explain):
<input type="checkbox"/> Chronic back problems	<input type="checkbox"/> Orthopedic problems (please detail area):
<input type="checkbox"/> Arthritis (please detail area):	<input type="checkbox"/> Other medical restrictions. Please explain:

LIST ALL MEDICATIONS YOU ARE TAKING (PRESCRIPTION AND OVER-THE-COUNTER).

Medication:	Reason for medication
Medication:	Reason for medication:
Medication:	Reason for medication:

I verify I have answered these questions truthfully and to the best of my knowledge. If I have a change in my health status during the course of my exercise program, I will notify the staff immediately.

Signature	Date
Name (Please Print):	



FORM 4 | MEDICAL CONSULTATION

FIRST NAME

LAST NAME

EMPLOYEE ID#

Note to Physician

This individual would like to participate in a fitness program offered by Health Fitness Corporation, however, the individual has indicated health history information that precludes HFC from allowing him/her to participate in the

fitness program without your consent and recommendations, if any. Please complete the Medical Recommendations section below and return this form to the individual at your earliest convenience.

Description of Program

If admitted to the health and fitness program, the individual will be given the option of completing an assessment of his or her current fitness level by completing either (a) HFC's Quick Fit Check, consisting of measuring resting heart rate and blood pressure, height, and weight; or (b) HFC's Full Fitness Assessment, consisting of a series of non-diagnostic assessments that may include the measurement of an individual's resting heart rate and blood pressure, body composition, girth measurements, flexibility, cardio-respiratory conditioning, muscular strength and endurance.

Based on these tests, the participant's Health History information, and your recommendations, if any, an exercise program will be developed for the individual. A typical fitness program may include the following:

- 5 to 10 minute warm-up (light exercise and stretching)
- 10 to 45 minute aerobic activity (running, walking, stair stepping, bicycling, etc.)
- 10 to 30 minute strength training (resistance machines, free weights, floor exercises)
- 5 to 10 minute cool-down (stretching and flexibility activities)

Examination Results

HEIGHT:	LUNGS:	<input type="checkbox"/> normal	<input type="checkbox"/> abnormal	Comments:
WEIGHT:	HEART:	<input type="checkbox"/> normal	<input type="checkbox"/> abnormal	Comments:
RESTING HEART RATE:	MUSCULOSKELETAL:	<input type="checkbox"/> normal	<input type="checkbox"/> abnormal	Comments:
CHOLESTEROL LEVEL:				

Medical Recommendations: Check one recommendation option below and complete associated questions, if any.

- This individual may NOT participate in the fitness center program based on the following limitations:
- This individual may participate without restriction in all fitness center activities.
- This individual may participate in the fitness center program with the following limitations:

Is there a maximum heart rate this individual should not exceed during aerobic exercise other than what is recommended for the participant's age and fitness level? YES NO If yes, please specify beats per minute:

The following program(s) are recommended (check all that apply):

- Nutrition analysis
- Weight loss
- Pre/Post-natal exercise
- Flexibility improvement
- Muscle strengthening
- Aerobic conditioning
- Back care
- Stress management
- Blood pressure monitoring
- Other

Exercise DOs and DON'Ts for the following orthopedic issue:

Other:

Physician Information

NAME (PLEASE PRINT)	SIGNATURE	DATE
ADDRESS	CITY	STATE ZIP CODE PHONE

If you would like to discuss this Medical Consultation Form in detail, please contact the Revisions Fitness Center Program Director at 312.220.1348.



FORM 5 | RELEASE OF LIABILITY AND INFORMED CONSENT

In consideration of the opportunity to receive fitness assessment services, participate in Health Fitness Corporation (HFC) programs and/or use Revisions Fitness Center (REVISIONS) facilities, I hereby assume all risks of injury, illness, death or other loss arising from or in any way relating to my participation in HFC programs and use of REVISIONS.

I hereby release, agree not to sue, and forever discharge Leo Burnett Company, Inc. (CLIENT) and HFC and their respective Affiliates* (as defined below) of and from any and all manner of claims, demands, actions, causes of action, liability, damages, claims for punitive or liquidated damages, claims for attorney's fees, costs and disbursements, individual or class action claims, and demands of any kind whatsoever, I have or might have against them or any of them, whether known or unknown, in law or equity, contract or tort, arising out of or in any way relating to my receipt of assessment services, participation in HFC programs, use of REVISIONS and loss of personal property, however originating or existing. This release shall be binding upon my heirs, personal representatives, administrators, executors, and assigns.

I understand that this release includes, without limitation, all injuries which may occur as a result of the following: (a) my use of HFC's amenities and equipment in REVISIONS facilities, my receipt of instruction and other services from HFC, or my participation in any activity, class, program, or instruction; (b) the malfunctioning of any equipment; (c) HFC's training, supervision, or dietary recommendations; and (d) my slipping and/or falling while in or on REVISIONS premises, including hallways, stairways, and elevators.

I further understand that any recommendations regarding exercise or diet (including, without limitation, the use of supplements) are entirely my responsibility and that I should consult a physician prior to undergoing any changes in exercise or diet.

I understand, as a participant of the health and fitness program who is to be assessed and given the opportunity to participate in an exercise program at REVISIONS, I will have the option to receive a fitness assessment that measures some or all of the following items: (1) flexibility; (2) muscular strength and endurance; (3) body composition; and (4) changes in heart rate and blood pressure before, during, and after an exercise test. I understand a particular set of results from the fitness assessment does not necessarily mean I am: (1) fit, (2) unfit, or (3) likely to benefit from exercise or changes in diet. That judgment can only be made by my physician.

I am aware that the fitness assessment is for the purpose of designing a personal exercise program and providing information on conditioning levels compared to norms. I understand the fitness assessment is not intended to replace any medical screening I may need, and neither REVISIONS, HFC, CLIENT, nor any of their Affiliates, will determine whether an exercise program or dietary change are medically appropriate for me. I understand it is my responsibility to consult with my physician regarding these matters.

I further understand HFC staff will question me about my health status, and I agree to complete a health history questionnaire. I certify the information I provide to HFC staff about my health and exercise history and current health status will be, to the best of my knowledge, complete and accurate, and I agree and understand it is my responsibility to inform HFC staff in the event of any change in my health or medical status. HFC shall treat information regarding my personal health and medical status as confidential. HFC shall not release such information without my written consent, except: to authorized HFC and CLIENT employees, agents, successors, and assigned contractors who we use to support our business; in connection with any programs sponsored by my employer in which I participate; in connection with the sale, assignment, or other transfer of the business which the information relates; when applicable by laws, court orders or government regulations require us to do so; and to health care personnel for treatment purposes (including, for example, emergency assistance personnel). I understand that HFC may use or disclose to others information regarding my health for statistical analysis or other research purposes, provided that my name and other personally identifiable information will be removed from the information prior to such uses and disclosures.

I understand there are possibilities of injury or other complications, including but not limited to musculoskeletal injuries, cardiovascular trauma, neurological impairment, heart attack and even death, which may occur during fitness assessment, while completing an exercise program, while otherwise using REVISIONS facilities, or while participating in any health and fitness program activities.

I voluntarily agree to submit to a fitness assessment, which can increase heart rate and blood pressure, and to assume all risks associated with my participation in the fitness assessment, health and fitness programs, (including a personal exercise program) and use of REVISIONS facilities. I understand and acknowledge it is my responsibility not to exceed the guidelines established for me on my exercise program card and in other program materials.

I understand use of REVISIONS and participation in a fitness assessment, health and fitness program activities is strictly voluntary, is not required of employees of participating companies, and I may discontinue my participation at any time. I further understand HFC may revoke my privileges to use REVISIONS or otherwise participate in assessment or other programs at any time, in its sole discretion. I agree to be bound by and obey all the rules and policies of REVISIONS, CLIENT, HFC, and HFC staff in my use of REVISIONS and in my participation in the health and fitness program activities.

I understand at any time I may review this Release of Liability and Consent by requesting a copy from HFC staff. I agree if any portion of this form is held invalid, the remainder of this form will continue in full legal force and effect.

I have carefully read this Release of Liability and Consent and fully understand its terms. I sign it voluntarily with full knowledge of its legal significance and understand that I have the right to have my attorney review it. I am 18 years of age or older.

Signature

Date

Print Name

*"Affiliates" means any person or entity which directly or indirectly, through one or more intermediaries, Controls, is Controlled by, or is under common Control with such person or entity and "Control" means possession, directly or indirectly, of power to direct or cause the direction of management or policies (whether through ownership of voting securities, by agreement or otherwise); and such person's or entity's present and former officers, directors, shareholders, trustees, employees, agents, representatives, contractors, and the successors and assigns of each, whether in their individual or official capacities.



FORM 6 | POLICIES AND PROCEDURES

- All members are required to be employed by Leo Burnett Company, Inc. or an approved affiliate.
- All members are encouraged to have a physical exam by their physician, prior to starting an exercise program.
- All members of REVISIONS are required to fill out a membership enrollment packet. This includes maintaining an updated health history form, which will be kept on file. Some members may be asked have a medical consultation prior to use of the center.
- All members are required to complete an evaluation and an orientation appointment prior to having full member access.
- All members are asked to check-in at computers upon entry of the fitness center to ensure accurate facility usage.
- Please be considerate and conscientious of other members at all times.
- Please limit use of cardiovascular equipment to 30 minutes during peak exercise times.
- Please use the provided wipes to wipe down equipment after use.
- Eating or drinking, except for water, in the workout area is prohibited.
- Proper attire, including athletic shoes, must be worn at all times, with the exception of specialty classes.
- The dropping or slamming of any weights is strictly prohibited.
- Please return items to their appropriate location after use.
- Used towels and clothes bags should be deposited in the dirty towel bin prior to exiting REVISIONS.
- Persons may be asked to leave the fitness center at any time for dangerous or inappropriate behavior.
- REVISIONS is not responsible for personal items. It is recommended that valuables be secured in the provided lockers for your protection.
- Large lockers are for daily use only. Please remove any personal items prior to exiting the center. Any items left in the lockers overnight will be removed.
- It is your responsibility to bring your personal locker key. If lost or stolen, a replacement key can be reordered at no additional fee.
- Members are liable for any personal injury and for any damage to the property of REVISIONS during their use.
- REVISIONS and the REVISIONS' employees are exempt from all responsibility for lost or stolen property or injuries sustained while participating in any activity related to or inside of the center.
- If an emergency occurs, contact a REVISIONS staff member immediately. 9-911 can be dialed from any phone.
- In the event of a building emergency, REVISIONS must be evacuated immediately.
- _____ (Initials) Written notice is required to cancel membership. Required cancellation form must be turned in on or before the 15th of the month prior to the month member desires cancellation to be processed and payroll deduction stopped.
- _____ (Initials) Membership will not be cancelled until locker key is returned or reported lost.
- _____ (Initials) If membership is cancelled, member can continue to use REVISIONS until the last day of the month.

I have read, understand and will abide by all the policies stated above, posted, stated, and any additional policies that may become necessary from time to time. I am aware that breaches will be documented and may result in termination of my membership at any time, without any expectation of a refund.

Signed _____

Date _____

Staff Witness _____

Date _____

