FORM 1 | ABOUT YOU

DATE COMPLETED ___|___|___

FIRST NAME	LAST NAME	EMPLOYEE ID #
DATE OF BIRTH	GENDER	WORK EMAIL
BUSINESS	SUITE NUMBER	WORK PHONE
HOME PHONE	HOME ADDRESS	CITY/ZIP
PRIMARY PHYSICIAN	PHYSICIAN PHONE	PHYSICIAN FAX
EMERGENCY CONTACT NAME	EMERGENCY CONTACT PHONE	RELATIONSHIP

EMPLOYMENT STATUS ☐ Full-time ☐ Part-time ☐ Temporary ☐ Intern ☐ Other:

HOW DID YOU HEAR ABOUT THE FITNESS CENTER? _____

ACTIVITY 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

OVERALL HEALTH LEVEL

How would you rate your current level of health?

☐ Poor ☐ Fair ☐ Good ☐ Excellent

SERVICE|ACTIVITY INTERESTS

In what services, programs, activities or equipment do you have an interest?

☐ Personal Training ☐ Walking Program ☐ Strength Training ☐ Cardiovascular Conditioning

☐ Sports Injury Prevention ☐ Group Exercise Classes ☐ Stretching/Flexibility ☐ Sports Conditioning

HEALTH INTERESTS

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

☐ Cholesterol/Blood Pressure ☐ Diabetes ☐ Weight Management ☐ Women's Health

☐ Tobacco Cessation ☐ CPR/First Aid ☐ Work Injury Prevention ☐ Men's Health

☐ Back Care ☐ Ergonomics ☐ Stress Management ☐ Children's Health

☐ Cancer Awareness ☐ Nutrition ☐ Self-Care ☐ Other

FORM 2 | HEALTH HISTORY QUESTIONNAIRE

FIRST NAME	LAST NAME	EMPLOYEE ID #

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 ☐ Yes ☐ No
(systolic BP>140 or diastolic BP>90mmHG on at least two separate checks)

Coronary angioplasty or cardiac surgery ☐ Yes ☐ No

Heart disease, heart attack, angina ☐ Yes ☐ No

Heart murmur ☐ Yes ☐ No

Peripheral vascular disease ☐ Yes ☐ No

Stroke ☐ Yes ☐ No

Other: ☐ Yes ☐ No

METABOLIC

Diabetes ☐ Yes ☐ No

Kidney disease ☐ Yes ☐ No

Thyroid or other metabolic disorders ☐ Yes ☐ No

RESPIRATORY

Asthma ☐ Yes ☐ No

Chronic bronchitis ☐ Yes ☐ No

Emphysema or chronic obstructive pulmonary disease (COPD) ☐ Yes ☐ No

Other: ☐ Yes ☐ No

If you marked "yes" to **one or more** of the items above, you must obtain your personal physician's consent prior to scheduling your orientation. See Medical Consultation Form

DO YOU CURRENTLY HAVE ANY OF THE FOLLOWING SIGNS, SYMPTOMS, OR CONDITIONS? MARK ALL THAT APPLY.

Ankle swelling ☐ Yes ☐ No

Chest pain (at rest or exertion) ☐ Yes ☐ No

Dizziness/fainting ☐ Yes ☐ No

WOMEN: Are you pregnant? ☐ Yes ☐ No

Rapid heartbeats or palpitations ☐ Yes ☐ No

Shortness of breath (at mild exertion/rest) ☐ Yes ☐ No

Unexplained fatigue (unusual fatigue or shortness of breath with usual activities) ☐ Yes ☐ No

If you marked "yes" to **one or more** of the items above, you must obtain your personal physician's consent prior to scheduling your orientation. See Medical Consultation Form.

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

Female, age 55 or older ☐ Yes ☐ No

Male, age 45 or older ☐ Yes ☐ No

Smoking habit (within past six months) ☐ Yes ☐ No

Hypercholesterolemia, elevated cholesterol, abnormal blood lipids (total cholesterol>200mg/dL or HDL<mg/dL) ☐ Yes ☐ No

Sedentary lifestyle (inactive job with no regular exercise program; active less than 3 times per week; or no recreational pursuits) ☐ Yes ☐ No

If you marked "yes" to **two or more** of the items above, you must obtain your personal physician's consent prior to scheduling your orientation. 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:

☐ Anemia (severe<10GM/dL)	☐ Allergies (please explain):
☐ Chronic back problems	☐ Orthopedic problems (please detail area):
☐ Arthritis (please detail area):	☐ Other medical restrictions. Please explain:

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

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
Signature of parent or guardian if participant under 18	Parent or guardian name (please print)

REVIEW DATE	CHANGES	IF YES, DESCRIBE CHANGES BELOW:	STAFF INITIALS
	☐ Yes ☐ No		
	☐ Yes ☐ No		

NOTE: If changes are indicated, the participant (and physician, if necessary), should complete a new form before retesting.

REVISIONS

FORM 3 | 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:	☐ normal	☐ abnormal	Comments:
WEIGHT:	HEART:	☐ normal	☐ abnormal	Comments:
RESTING HEART RATE:	MUSCULOSKELETAL:	☐ normal	☐ 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

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FORM 4 | 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 Corporate Fitness Center (CENTER) 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 CENTER.

I hereby release, agree not to sue, and forever discharge Manufacturers Life Insurance Co. (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 the CENTER 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 the CENTER 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 the CENTER's premises, including adjacent sidewalks and parking areas.

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 the CENTER, 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 the CENTER, HFC, 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 the CENTER facilities, or while participating in any health and fitness program activities.

I voluntarily agree to submit to a fitness assessment 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 CENTER 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 the CENTER 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 the CENTER 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 the CENTER, HFC and HFC staff in my use of the CENTER 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 _____

REVISIONS

FORM 5 | POLICIES AND PROCEDURES

- All members are required to be employed by a tenant-corporation of the REVISIONS Corporate Fitness Center.
- All members are encouraged to have a physical exam by their physician, prior to starting an exercise program.
- All members of the center 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.
- Any members on an annual, pre-paid or corporate membership is responsible for membership fees for the entire length of their contract or pre-paid term. Medical conditions or termination of employment are exceptions to this policy. A medical release and/or verification from the employer's HR department will be required for any cancellation and/or refund.
- Guests must be tenants of the REVISIONS Corporate Fitness Center. Guests must provide identification and sign a guest waiver prior to use of the center.
- All members are required to check-in upon entry of the fitness center.
- 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 wipe down equipment after use.
- Eating or drinking (except for water) in the workout area is prohibited.
- Proper attire must be worn at all times.
- The dropping or slamming of any weights is strictly prohibited.
- Please return items to their appropriate location after use.
- Used towels should be deposited in the dirty towel bin prior to exiting the center.
- Persons may be asked to leave the fitness center at any time for dangerous or inappropriate behavior.
- Sauna use is not recommend immediately prior to or after exercise. Please do not place water onto the electric coals of the sauna.
- REVISIONS Corporate Fitness Center is not responsible for personal items.
- 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.
- Members are liable for any personal injury and for any damage to the property of the REVISIONS Corporate Fitness Center during their use.
- The REVISIONS Corporate Fitness Center and Publicis/ Tenant of 55 W. Wacker 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 staff member immediately. 911 can be dialed from the phone in the laundry room.
- In the event of a building emergency, the fitness center must be evacuated immediately.
- In the event of a tornado, stay in the fitness center, and protect yourself from windows and mirrors.

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_____ Dated _____

REVISIONS

Payroll Deduction Form

Employee Name:_____ Employee ID#:_____
Ext:_____ Floor: _____ Employer: _____

Have you ever been a REVISIONS member before? **YES** **NO**

If YES, please print your cancellation date (month/ year): _____

Does your employee badge allow you access to 35 W. Wacker? **YES** **NO**

Please check the appropriate line:

Publicis Groupe Employee ($10.00 per paycheck) _____

Paid Publicis Groupe Intern ($10.00 per paycheck) _____

Publicis Groupe VP/SVP (No Deduction) _____

Publicis Groupe Freelance ($20.00 per month) _____

Tenant of 55 West Wacker (see REVISIONS staff for pricing) _____

I authorize my employer to automatically make the correct deduction indicated above, from my bi-monthly/ monthly paycheck **OR** I authorize REVISIONS to automatically make the correct deduction indicated below from my debit/ credit card at the beginning of each month. This authorization will remain in force until I notify the REVISIONS Fitness Center staff, complete a "Member Cancellation Form", and turn in all keys/ keycards as issued.

Signature: _____ Date: _____

REVISIONS Fitness Center **55 W. Wacker 2nd Floor, Chicago, IL** ***Direct*** **312.220.1348** ***Fax*** **312.220.0794**

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