UNIVERSITY
OF
CALIFORNIA

work STRONG
University of California

UC WorkStrong Participant Information

Date: ____/____/____

Full Name: ____ Employee ID: ______________________

Phone: ______________________ Cell Phone: ______________________

Email: ____ Department: ______________________

Preferred method of communication (choose one): ☐ Phone ☐ Email ☐ Either

Location Preference: ____

Please list the hours you are available for your session. Be specific:

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday

What is your occupation/work type? ____

Please describe your current injury. Include diagnosis if known.

Are you currently in physical therapy? ☐ Yes ☐ No Did you complete physical therapy? ☐ Yes ☐ No

Please list any current physical limitations related to your current injury:

Please list any past (over a year ago) injuries:

Please list prescriptions and non-prescription medications you are currently taking:

Please describe your current exercise routine:

Please detail your fitness and training goals:

☐ *I give my permission for the WorkStrong program to release information about my health and any WorkStrong forms I have completed to WorkStrong service providers in order to personalize my WorkStrong program.*

Signature: ______________________________ Print Name: ____