How to Write SOAP Notes

Let's examine each category in detail and drill down on what you need to include in a SOAP note.

1. Subjective

The first step is to gather all the information the patient has to share about their symptoms. The patient will tell you about their experience with the symptoms and condition, as well as what they perceive to be their needs and goals for treatment.

The Subjective summary should include direct quotes from the client. For example, a patient might say, "I am having problems with my balance." The provider would add this verbatim quote. It's crucial to record the patient's words, rather than paraphrasing them, so you cultivate the most accurate insight into their condition.

The Subjective category is also an appropriate place to list any comments made by the patient, their family members or their caretakers. This category is the basis for the rest of your notes as well as your treatment plan, so getting the highest-quality information possible is important. The OLD CHARTS acronym provides a smart way to cover a patient's presenting problem thoroughly.

- **O**nset: Determine when each symptom started.
- **L**ocation: Find out the primary location of pain or discomfort.
- **D**uration: Learn how long the patient has dealt with their symptoms.
- **C**haracter: Examine the types of pain — aching, stabbing, etc.
- **A**lleviating or aggravating factors: What actions or interactions reduce or increase the severity of the patient's symptoms?
- **R**adiation: Find out if the pain radiates to other locations in the body.
- **T**emporal pattern: Do the symptoms appear in a pattern, like in the evenings or after meals?
- **S**ymptoms associated: Are there any secondary symptoms that accompany the patient's main complaint?

2. Objective

The Objective portion of a SOAP note includes factual information. It may include detailed observations about the patient's appearance, behavior, body language, and mood. For example, you might write that the client arrived 15 minutes late to the session and slouched in the chair.

Write details down as factually as possible. The Objective phase is only about raw data, not conclusions or diagnoses on your part. Record any measurable data during the patient's session, including applicable test scores.

Documenting the Objective phase brings up the issue of separating symptoms from signs. Symptoms are the patient's experience of their condition, whereas signs are objective observations related to symptoms.

You have a limited window for examination, so it's crucial to actively look for any signs that complement or contradict information given in the Subjective section of the notes.

3. Assessment

Both the Subjective and Objective elements previously recorded come into effect in the Assessment phase. You will document your impressions and make interpretations based on the information you've gathered. For an initial visit, the Assessment portion of your notes may or may not include a diagnosis based on the type and severity of symptoms reported and signs observed.

For common conditions such as vision loss, the Assessment is fairly straightforward and can often lead to a diagnosis in the first visit or two. For rarer and more complex conditions or those that appear co-morbidly, you may need more time to gather information on the Subjective and Objective levels before arriving at a diagnosis.

For follow-up visits, the Assessment portion of SOAP notes covers an evaluation of how the client is progressing toward established treatment goals. The Assessment will inform your current treatment course as well as future plans, depending on whether the patient is responding to treatment as expected. It's essential to reflect on whether your patient is showing improvement, maintaining improvements already made, worsening or demonstrating patterns of remission.

Like the other sections of SOAP notes, your Assessment should only contain as much information as is necessary. Some Assessments will be significantly longer than others, based on the complexity of the patient's condition. Sometimes this section of your notes will contain only a few snippets of information like, "Patient is having better balance." In other situations, there are more pieces to evaluate, and the Assessment portion of your notes should extend to include all the appropriate information.

4. Plan

This is where the previous three sections all come together to help you determine the course of future treatment. The Plan section of your SOAP notes should contain information on:

- The treatment was given during the session and your rationale for administering it
- The patient's immediate response to the treatment
- When the patient's next appointment will be
- Any instructions you gave the patient, including homework assignments
- Goals and outcome measures for new problems or problems being re-assessed

Your Plan notes should include actionable items for each diagnosis. If your patient is experiencing multiple conditions your notes should include separate plans for each condition.

The goal of this section is to address all the specific problems listed in the Assessment. When done efficiently, the Plan sets a clear roadmap for the patient's continuing treatment and provides a window of insight for other provider to continue that treatment if need be. Consult the Plan on each new visit, and adjust it regularly based on the findings in the Assessment section.