s.o.a.p. notes

client name

session type

date

duration

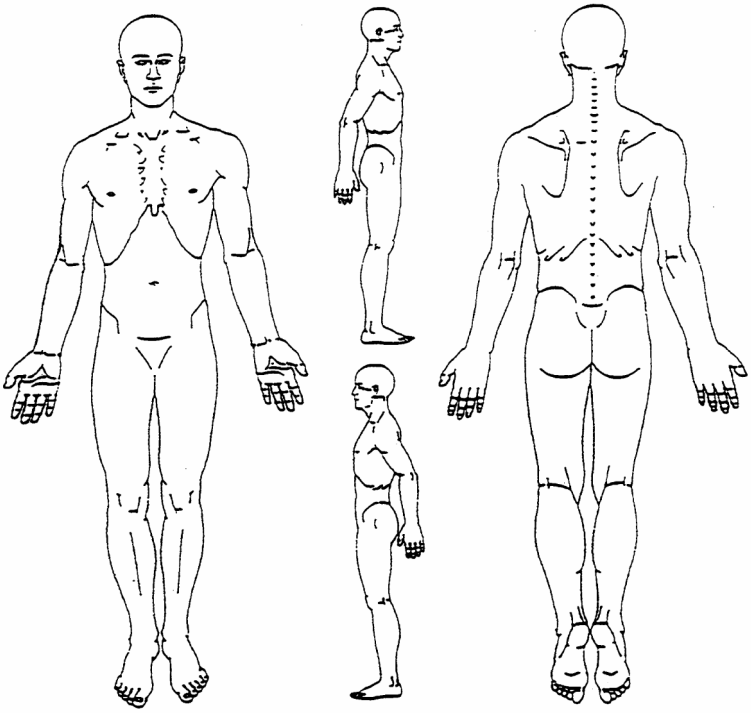
S (Subjective) Client symptoms and information given by referring healthcare provider and by client.

O (Objective) Clinical observations derived from interview, palpation, visual exam and posture assessment.

A (Assessment/Application) Treatment used and client response to treatment.

P (Plan of Treatment) Treatment options, recommendations and self-care plan.

symptoms: location/intensity/duration/frequency/onset



✘ Adhesion	≈ Spasm
Rotation	Inflammation
○ Pain	Trigger point
• Tender Point	/ Elevation
≡ Hypertonicity	

additional notes

insurance ID number

date of injury

modality type (code) duration

modality type (code) duration

current medications