

## Tips for SOAP Note Writing

### **S: Subjective**

- Prognostic factors (e.g., motivated, makes needs known)
- Symptoms and complaints (e.g., seemed sleepy, seemed stressed from a long day at school, c/o shoulder pain)

### **O: Objective**

- Performance toward all goals in measurable, objective, skilled terminology. If a goal from the Lesson Plan was not targeted, state the reason.
- Discussion from caregiver/client conferences or training

### **A: Assessment**

- Professional opinion made by the clinician about the effectiveness and appropriateness of the treatment plan (e.g., criterion for a goal is too low), client's response to treatment (e.g., enjoys the paper-and-pen activities), problems encountered (e.g., distracted by the mirror), etc. This will include an explanation of any need to modify the treatment plan.
- Progress toward functional outcomes
- Progress compared to past performance (perhaps week-to-week, if indicated)
- Justification for continued treatment (periodically)

### **P: Plan**

- Services to be provided
- Specific activities or approaches to be tried
- Details of modifications to the treatment plan. Type any new goals just as they would appear on an Initial Therapy Plan. Specify goals to be d/c'd.
- Recommendations (e.g., for other consults, important factors related to treatment, etc.)