APSU Writing Center

SOAP Note-Taking Method

SOAP (Subjective/Objective/Assessment/Plan) Notes

- SOAP notes are a standardized method used in healthcare settings, such as clinics, hospitals, and nursing, to document patient care. They help improve the quality of patient care by providing a clear, structured way to document and recall details about a specific case.

Subjective (S)

- This section captures the patient's stated experiences, feelings, and concerns.
  - Patient's perspective, symptoms, and relevant medical history.
  - Quotes or direct statements from the patient.
  - Observations about the patient's behavior (e.g., if they appeared sick, tired, attentive, on time, or late).
- **Example:** "Mason was participatory and engaged throughout the therapy session. He was talkative and maintained a generally positive affect throughout."

Objective (O)

- This section includes observable and measurable data collected by the clinician.
  - Factual, measurable, and objective information.
  - Results from labs, x-rays, vital signs, and focused physical exams.
  - Goals set for the patient. (e.g., specific performance metrics, exercise targets).
- **Example:** "Hortensia accurately produced the target sound /r/ in 60% of opportunities."

Assessment (A)

- The clinician's professional judgment and diagnosis based on the subjective and objective data.
  - A narrative describing what happened during the session.
  - Comparison of progress or regression compared to previous sessions.
  - Identification of any patterns or inconsistencies.
  - Potential barriers to success, such as environmental factors, cognitive limitations, or emotional states.
- **Example:** "Jay's accuracy was decreased from last week, which is suspected to be due to his limited ability to sustain attention throughout the session."

Plan (P)

- The treatment plan, follow-up actions, and next steps.
  - A brief, clear statement about future sessions, including any modifications to the treatment plan.
  - Referrals to other specialists or follow-up tests, if needed.
  - Expected outcomes and a timeline for reevaluation.
- **Example:** "Next session, Susanna will focus on the production of word-initial bilabial stops /p/ and /b/."

Austin Peay State University
CLARKSVILLE TENNESSEE

SOAP Note

Client Name: **Date of Service:**

OBJECTIVES

SUBJECTIVE

OBJECTIVE

ASSESSMENT

PLAN

☐ **Continue current plan** ☐ **Objective met**

Revise plan:

STUDENT CLINICAL SIGNATURE: **DATE:**

CLINICAL SUPERVISOR SIGNATURE: **DATE:**

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References

Graduate Writing Center (2022). *SOAP Notes: A Writer's Guide.* University of Vermont. https://www.uvm.edu/sites/default/files/Graduate-Writing-Center/GWC%20Guides/Genres/SOAP_Notes_101.pdf

The University of New Mexico (2022). Template for Clinical SOAP Note Format. https://fcm.unm.edu/education/images/docs/template_clin_soap_note.pdf

Miklasova, A. (2024, September 25). *How to write a SOAP note - including real-life examples.* UpHeal. https://www.upheal.io/documentation/soap-note-example