

**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/."

## SOAP Note

**Client Name:**

**Date of Service:**

<b>OBJECTIVES</b>	
<b>SUBJECTIVE</b>	
<b>OBJECTIVE</b>	
<b>ASSESSMENT</b>	
<b>PLAN</b>	
<input type="checkbox"/> Continue current plan	<input type="checkbox"/> Objective met
<b>Revise plan:</b>	
<b>STUDENT CLINICAL SIGNATURE:</b>	<b>DATE:</b>
<b>CLINICAL SUPERVISOR SIGNATURE:</b>	<b>DATE:</b>



## APSU Writing Center 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](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](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>