SOAP NOTE

Subjective, Objective, Assessment, Plan

Patient: _____ Date: _____

Practitioner: _____ Session length: _____

Visit type: ☐ Initial visit ☐ Follow-up ☐ Re-assessment

S Subjective

What the patient tells you

Main complaint

_____

_____

How did it start?

☐ Car accident ☐ Fall

☐ Sports or exercise ☐ Work-related

☐ Slept wrong ☐ Gradual / not sure

☐ Other: _____

Onset date: _____

Pain level today (0 to 10)

0 1 2 3 4 5 6 7 8 9 10

How does it feel?

☐ Dull / aching ☐ Sharp ☐ Burning

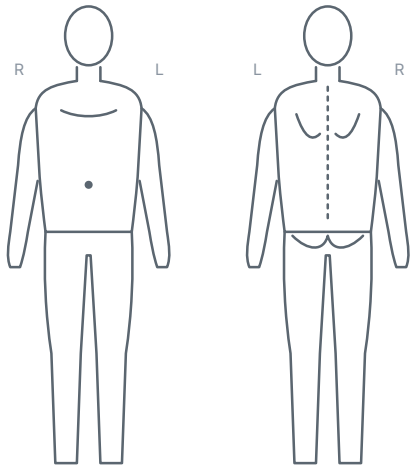
☐ Throbbing ☐ Numb / tingling ☐ Stiff

How often?

☐ Constant ☐ Comes and goes

☐ Worse in the morning ☐ Worse at night

Mark the areas on the body chart



P Pain S Stiffness

N Numbness X Trigger point

T Tingling M Muscle spasm

What makes it worse?

_____

What makes it better?

_____

Does it limit any of these?

☐ Work ☐ Sleep

☐ Exercise ☐ Daily tasks

Already seen someone for this?

☐ Chiropractor ☐ Massage therapist

☐ Physiotherapist ☐ Doctor

SOAP NOTE

Patient: _____ Date: _____

O Objective

What you observe and measure

Posture & observation

HEAD & NECK

- ☐ Neutral
- ☐ Forward head
- ☐ Tilt L
- ☐ Tilt R

SHOULDERS

- ☐ Level
- ☐ Rounded
- ☐ High L
- ☐ High R

SPINE

- ☐ Normal curves
- ☐ Increased lordosis mild / mod / severe
- ☐ Increased kyphosis mild / mod / severe
- ☐ Scoliosis mild / mod / severe

PELVIS

- ☐ Level
- ☐ High L
- ☐ Anterior tilt
- ☐ High R
- ☐ Posterior tilt
- ☐ Rotation

Range of motion

REGION	FULL	LIMITED	PAINFUL	NOTES
Neck (cervical)	☐	☐	☐	
Mid back (thoracic)	☐	☐	☐	
Low back (lumbar)	☐	☐	☐	
Shoulder L / R	☐	☐	☐	
Hip L / R	☐	☐	☐	
Other:	☐	☐	☐	

Palpation

Area: _____

- ☐ Muscle tension mild / mod / severe
- ☐ Tenderness mild / mod / severe

Tissue: ☐ Normal ☐ Fibrotic ☐ Adhesions

Temperature: ☐ Normal ☐ Warm ☐ Cool

Orthopedic & neurological tests (test, side, result)

SOAP NOTE

Patient: _____ Date: _____

A Assessment

Your clinical impression

Clinical impression

Response to today's treatment

☐ Improved ☐ No change ☐ Worse

Progress since last visit

☐ Better ☐ Same ☐ Worse

Treatment performed today

AREA	TECHNIQUE / MODALITY	TIME

P Plan

Next steps for the patient

Recommended visits: _____ Next appointment: _____

Home care

☐ Stretching ☐ Strengthening ☐ Ice

☐ Heat ☐ Posture / ergonomics ☐ Activity changes

Referral to: _____

Plan notes

Practitioner signature: _____ Date: _____

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Saved to the record

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