15 SOAP NOTE EXAMPLES for VARIOUS PRACTITIONERS

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15 SOAP note examples and templates

Although the above sections help outline the **requirements of each SOAP notes section**, having an example in front of you can be beneficial. That's why we've taken the time to collate some examples and SOAP note templates we think will help you write more detailed and concise SOAP notes.

SOAP note example for nurses or Nurse practitioners

Subjective

John reports that he is feeling 'tired' and that he 'can't seem to get out of bed in the morning.' John is 'struggling to get to work' and says that he 'constantly finds his mind wandering to negative thoughts.' John stated that his sleep had been broken and he does not wake feeling rested. He reports that he does not feel as though the medication is making any difference and thinks he is getting worse.

Objective

John was unable to come into the practice and so has been seen at home. John's personal hygiene does not appear to be intact; he was unshaven and dressed in track pants and a hooded jumper which is unusual as he typically takes excellent care in his appearance. John appears to be tired; he is pale in complexion and has large circles under his eyes.

John's compliance with his new medication is good, and he appears to have retained his food intake. Weight is stable and unchanged.

Assessment

John presents with symptoms consistent with a major depressive episode. This is evidenced by his low mood, slowed speech rate and reduced volume, depressed body language, and facial expression. However, it's important to note that this assessment is based on the information presented and a full diagnosis can only be confirmed by a qualified mental health professional.

Further exploration is needed to understand the duration and severity of these symptoms, as well as any potential contributing factors such as life stressors, medical

conditions, or personal history. Additionally, while suicidal ideation is currently denied, it is crucial to monitor for any changes and ensure appropriate safety measures are in place.

Plan

Diagnosis: Major Depressive Disorder, Recurrent, Severe (F33.1 ICD-10) - Active

Problem: Depressed Mood

Rationale: John's depressed mood, evidenced by ongoing symptoms consistent with Major Depressive Disorder, significantly impacts his daily life and requires continued intervention.

Long-term goal: John will develop skills to recognize and manage his depression effectively.

Short-term goals and interventions:

1. Maintain treatment engagement: Continue attending weekly individual therapy sessions to address negative thinking patterns, build coping mechanisms, and monitor progress.
2. Optimize medication: Collaborate with the prescribing physician to continue titration of the SSRI fluoxetine as needed, ensuring optimal symptom control.
3. Engage in daily physical activity: Encourage participation in structured physical activity, such as walking Jingo once a day, to improve mood and energy levels.
4. Implement a safety plan: Develop a collaborative safety plan with John outlining clear steps and resources he can access in moments of suicidal ideation, ensuring his safety and well-being.

SOAP note example for psychotherapists

Subjective

Stacey reports that she is 'feeling good' and enjoying her time away. Stacey reports she has been compliant with her medication and using her meditation app whenever she feels her anxiety.

Objective

Stacey was unable to attend her session as she is on a family holiday this week. She was able to touch base with me over the phone and was willing and able to make the phone call at the set time. Stacey appeared to be calm and positive over the phone.

Assessment

Stacey presented this afternoon with a relaxed mood. Her speech was normal in rate, tone, and volume. Stacey was able to articulate her thoughts and feelings coherently.

Stacey did not present with any signs of hallucinations or delusions. Insight and judgment are good. No sign of substance use was present.

Plan

Plan to meet again in person at 2 pm next Tuesday, 25th May. Stacey will continue on her current medication and has given her family copies of her safety plan should she need it.

SOAP note example for pediatricians

Subjective

Mrs. Jones states that Julia is "doing okay." Mrs. Jones said her daughter seems to be engaging with other children in her class. Mrs. Jones said Julia is still struggling to get to sleep and that "she may need to recommence the magnesium." Despite this, Mrs. Jones states she is "not too concerned about Julia's depressive symptomatology.

Objective

Mrs. Jones thinks Julia's condition has improved.

Assessment

Julia will require ongoing treatment.

Plan

Plan to meet with Julia and Mrs. Jones next week to review mx. To continue to meet with Julia.

SOAP note example for social workers

Subjective

Martin reports experiencing a worsening of his depressive symptoms, describing them as "more frequent and more intense" compared to previous experiences. He feels the depressive state is constantly present, with no improvement in anhedonia, and a significant decrease in energy levels compared to the previous month. He describes feeling constantly fatigued, both mentally and physically, and reports difficulty concentrating and increased irritability.

Importantly, Martin also shared experiencing daily thoughts of suicide, although he denies having a specific plan or intention to act on them.

Objective

Martin denies any hallucinations, delusions, or other psychotic-related symptomatology. His compliance with medication is good. He appears to have gained better control over his impulsive behavior as they are being observed less frequently. Martin appears to have lost weight and reports a diminished interest in food and a decreased intake.

Assessment

Martin presents with significant symptoms consistent with Major Depressive Disorder, including worsening mood, anhedonia, fatigue, difficulty concentrating, and daily thoughts of suicide. His verbal and cognitive functioning appears intact, with no signs of psychosis. He demonstrates some insight into his depression and denies any current plan or intent to act on his suicidal thoughts.

However, his nonverbal presentation paints a concerning picture, with listlessness, distractedness, slow physical movement, and depressed body language reflecting the severity of his depressive episode. It is crucial to monitor his safety closely and address the suicidal ideation with appropriate interventions, despite the lack of an immediate plan.

Therefore, continuing therapy sessions with a focus on developing coping mechanisms, managing suicidal ideation, and exploring potential contributing factors is highly recommended.

Plan

Diagnosis: Major Depressive Disorder (MDD) - Active

Rationale: Martin's ongoing symptoms of depression, including daily suicidal ideation and significant functional impairment, necessitate continued intervention and support.

Short-term goals and interventions:

1. Increase treatment frequency: Schedule follow-up therapy session in two days, on Friday, May 20th, to provide immediate support and monitor safety.
2. Reinforce safety plan: Review and reinforce Martin's existing safety plan, ensuring he understands and has accessible resources to address suicidal thoughts.
3. Encourage communication with family: Discuss the importance of informing a trusted family member about his current state of mind and seeking their support, while respecting Martin's autonomy concerning disclosure.

Additional considerations:

- Potential for medication management: Explore the potential benefits and risks of medication management, such as anti-depressants, in consultation with a physician, considering the severity and duration of symptoms.
- Collaboration with support systems: Consider involving other healthcare providers, such as Martin's primary care physician, in a coordinated care approach, if deemed necessary.

SOAP note example for psychiatrists

Subjective

Ms. M. describes her current state as "doing okay" with a slight improvement in her depressive symptoms. While she still experiences persistent sadness, she acknowledges slight progress. Her sleep patterns remain disrupted, although she reports improved sleep quality and manages to get "4 hours sleep per night."

During the session, Ms. M. expressed discomfort with my note-taking, causing her anxiety. Additionally, she mentioned occasional shortness of breath and a general anxiety related to healthcare providers. Interestingly, she expressed concern about the location of her medical records.

Objective

Ms. M. is alert. Her mood is unstable but improved slightly, and she is improving her ability to regulate her emotions.

Assessment

Ms. M. has a major depressive disorder.

Plan

Ms. M. will continue taking 20 milligrams of sertraline per day. If her symptoms do not improve in two weeks, the clinician will consider titrating the dose up to 40 mg. Ms. M. will continue outpatient counseling and patient education and handout. Comprehensive assessment and plan to be completed by Ms. M's case manager.

The SOAP note could include data such as Ms. M vital signs, patient's chart, HPI, and lab work under the Objective section to monitor his medication's effects.

SOAP note example for therapists

Subjective

"I'm tired of being overlooked for promotions. I don't know how to make them see what I can do." Frasier's chief complaint is feeling "misunderstood" by her colleagues.

Objective

Frasier is seated, her posture is rigid, eye contact is minimal. Frasier appears to be presented with a differential diagnosis.

Assessment

Frasier is seeking practical ways of communicating her needs to her boss, asking for more responsibility, and how she could track her contributions.

Plan

Book in for a follow-up appointment. Work through some strategies to overcome communication difficulties and lack of insight. Request GP or other appropriate healthcare professionals to conduct a physical examination.

SOAP note example for counselors

Subjective

David states that he continues to experience cravings for heroin. He desperately wants to drop out of his methadone program and revert to what he was doing. David is motivated to stay sober by his daughter and states that he is "sober, but still experiencing terrible withdrawals" He stated that [he] "dreams about heroin all the time, and constantly wakes in the night drenched in sweat."

Objective

David arrived promptly for his appointment, completing his patient information sheet in the waiting room while exhibiting a pleasant demeanor during the session. He displayed no signs of intoxication.

While David still exhibits heightened arousal and some distractibility, his ability to focus has improved. This was evident during his sustained engagement in a fifteen-minute discussion about his partner and his capacity for self-reflection. Additionally, David demonstrated a marked improvement in personal hygiene and self-care. His recent physical exam also revealed a weight gain of 3 pounds.

Assessment

David demonstrates encouraging progress in his treatment journey. He actively utilizes coping mechanisms, ranging from control techniques to exercises, resulting in a

decrease in his cravings, dropping from "constant" to "a few times an hour." This signifies his active engagement and positive response to treatment.

However, it is crucial to acknowledge that David still experiences regular cravings, indicative of his ongoing struggle. Coupled with his history of five years of heroin use, it underscores the need for further support. To consolidate his gains and progress towards sustainable recovery, David would benefit from acquiring and implementing additional coping skills.

Therefore, considering both his current progress and the underlying factors related to his substance use, David would likely benefit from the addition of Cognitive Behavioral Therapy (CBT) alongside his current methadone treatment. Integrating CBT can equip him with valuable tools for managing triggers, challenging negative thoughts, and developing healthy coping mechanisms, ultimately enhancing his long-term recovery potential.

Plan

David has received a significant amount of psychoeducation within his therapy session. The therapist will begin to use dialectical behavioral therapy techniques to address David's emotion dysregulation. David also agreed to continue to hold family therapy sessions with his wife. Staff will continue to monitor David regularly in the interest of patient care and his past medical history.

SOAP note example for occupational therapists

Subjective

Ruby stated that she feels 'energized' and 'happy.' She states that getting out of bed in the morning is markedly easier and she feels 'motivated to find work.' She has also stated that her 'eating and sleeping has improved,' but that she is concerned, she is 'overeating.'

Objective

Ruby attended her session and was dressed in a matching pink tracksuit. Her personal hygiene was good, and she had taken great care to apply her makeup and paint her nails. Ruby appeared fresh and lively. Her compliance with her medication is good, and she has been able to complete her jobseekers form.

Assessment

Ruby presented this morning with markedly improved affect and mood. Her speech was normal in rate and pitch and appeared to flow easily. Her thoughts were coherent, and her conversation was appropriate. Ruby's appearance and posture were different from

what they were in our last session. Ruby's medication appears to be assisting her mental health significantly.

Plan

Short-term goals and interventions:

1. Follow-up appointment: Schedule a follow-up session with Ruby in one week to monitor her progress and address any emerging concerns.
2. Open communication: Encourage Ruby to maintain open communication with me and contact me for any assistance or questions regarding her job search process. This fosters a collaborative approach and ensures timely support.
3. Medication adherence: Collaborate with Ruby to ensure continued adherence to her prescribed medication regimen, emphasizing its importance in managing her condition.
4. Multidisciplinary team (MDT) review: Share this latest session's information with Dr. Smith for review within the MDT meeting. This facilitates collaborative analysis, discussion of potential diagnoses, and formulation of a comprehensive treatment plan.

Additional considerations:

- Exploring potential vocational support: Depending on Ruby's needs and the MDT's recommendations, exploration of additional vocational support services might prove beneficial. This could include career counseling, interview preparation workshops, or specialized job search resources tailored to her specific situation.
- Addressing underlying factors: Further assessment is essential to identify any underlying factors contributing to Ruby's presentation, such as anxiety or depression, that might require additional interventions tailored to address them.

SOAP note example for dentists

Subjective

Chief complaint: A 56-year-old woman presents with a chief complaint of "painful upper right back jaw for the past week or so."

History of present illness: The patient reports experiencing pain in her upper right back jaw for approximately one week. She describes the pain as [insert patient's description of the pain, e.g., sharp, dull, throbbing, aching]. She states that the pain is [insert patient's description of pain characteristics, e.g., constant, intermittent, worse with specific activities]. She denies any history of fever, chills, facial swelling, difficulty swallowing, or earache.

Past medical history: The patient denies any significant past medical history.

Medications: The patient denies taking any current medications.

Allergies: The patient reports an allergy to paracetamol.

Social history: The patient reports a history of [insert details of tobacco use, e.g., smoking cigarettes for 30 years, one pack per day] and [insert details of alcohol consumption, e.g., occasional social drinking].

Objective

Vitals:

- Blood pressure: 133/91 mmHg
- Heart rate: 87 beats per minute
- Temperature: 98.7 °F (37.1 °C)

Clinical Examination:

Extraoral:

- No signs of swelling, asymmetry, pain, redness (erythema), numbness (paraesthesia), or tenderness to palpation (TMI) were observed in the external facial and jaw areas.

Intraoral:

- Tooth #17 (FDI #27) is supra-erupted and contacting (occluding) the pericoronal tissues (gum tissue surrounding the crown) of tooth #16.
- Tooth #16 is partially erupted and exhibits:
- Red, inflamed gum tissue (erythematous gingiva)
- Presence of discharge (exudate)
- Pain upon palpation

Radiology:

- Pending - X-rays (including periapical (PA) and panoramic (Pano) views, or possibly a CT scan) are recommended to further evaluate the underlying anatomy and identify any potential bone involvement.

Assessment

- Pericoronitis: The patient exhibits clinical signs consistent with pericoronitis affecting tooth #16. This includes the presence of: *Partial eruption of the tooth* Inflamed gum tissue (erythema) *Discharge (exudate) around the tooth* Pain upon palpation * Supra-eruption of the opposing tooth (#17) and its contact with the affected tissue

- Contributing factors: While a definitive cause cannot be established without further investigation, the patient's smoking history (one pack per week) could potentially contribute to the development of pericoronitis by compromising the immune response and increasing the risk of infection.
- Additional considerations: Further information is necessary to fully understand the underlying factors. Pending X-rays (PA and panoramic) will provide valuable insights into the bone structure and identify any potential complications, such as impaction or bone loss.

Therefore, a definitive diagnosis and comprehensive treatment plan will be determined following the completion of the X-ray studies and considering the patient's full medical history and any additional information gathered.

Plan

- Pain management: OTC pain meds (consider allergy) & warm compresses (10-15 min, several times/day).
- Definitive treatment: Schedule extraction of #17 after X-ray review.
- Antibiotics (pending): Consider 5-7 day course of amoxicillin based on X-ray and severity.
- Follow-up: See patient in 3-5 days (healing, post-op concerns, oral hygiene).
- Oral hygiene education: Instruct on proper brushing/flossing, gentle cleaning of affected area.
- Smoking cessation: Encourage quitting to improve healing and reduce infection risk.

SOAP note example for speech therapists

Subjective

Jenny's mother stated, "Jenny's teacher can understand her better now" Jenny's mother is "stoked with Jenny's progress" and can "see the improvement is helpful for Jenny's confidence."

Objective

Jenny was able to produce /l/ in the final position of words with 80% accuracy.

Assessment

Jenny's pronunciation has improved 20% since the last session with visual cues of tongue placement. Jenny has made marked improvements throughout the previous 3 sessions.

Plan

Jenny continues to improve with /l/ in the final position and is reaching the goal of /l/ in the initial position. Our next session will focus on discharge.

SOAP note example for Physical Therapists

Subjective

At the time of the initial assessment, Bobby complained of dull aching in his upper back at the level of 3-4 on a scale of 10. Bobby stated that the "pain increases at the end of the day to a 6 or 7". Bobby confirmed he uses heat at home and finds that a "heat pack helps a lot."

Objective

The cervical spine range of motion is within functional limit with pain to the upper thoracic with flexion and extension. Cervical spine strength is 4/5. The right lateral upper extremity range of motion is within the functional limit, and strength is 5/5. Palpation is positive over paraspinal muscles at the level of C6 through to T4, with the right side being less than the left. The sensation is within normal limits.

Assessment

Bobby is suffering from pain in the upper thoracic back.

Plan

To meet with Bobby on a weekly basis for modalities, including moist heat packs, ultrasound, and therapeutic exercises. The goal will be to decrease pain to a 0 and improve functionality.

SOAP note example for medical practitioners

Subjective

66-year-old Darleene presents for a follow-up appointment regarding her hypertension. She reports feeling well, denying any dizziness, headaches, or fatigue.

Medical history: Darleene has no significant past medical history beyond hypertension. Her current medication regimen consists solely of HCTZ 25mg daily.

Lifestyle: Over the past three months, Darleene has successfully lost 53 pounds by implementing a low-fat diet and incorporating daily 10-minute walks. Notably, she also acknowledges consuming two glasses of wine nightly. Darleene denies using any over-the-counter medications like cold remedies or herbal supplements.

Objective

- **Vital signs:**
- BP: 153/80 mmHg
- Pulse: 76 beats per minute
- Weight: 155 lbs
- Height: 55 inches
- BMI: ~30
- **General appearance:** Well-nourished, no acute distress.
- **HEENT:** Normocephalic, atraumatic, atraumatic, atraumatic (head, eyes, ears, nose, throat - all normal).
- **Neck:** Supple, no jugular venous distention (JVD).
- **Lungs:** Clear to auscultation bilaterally.
- **Heart:** Regular rate and rhythm, no murmurs.
- **Abdomen:** Soft, non-tender, no organomegaly.
- **Extremities:** No edema.

Assessment

Darleene is here for a follow-up of her hypertension. It is not well-controlled since blood pressure is above the goal of 135/85. A possible trigger to her poor control of HTN may be her alcohol use or the presence of obesity.

Plan

1. Lifestyle modifications:

- Continue low-fat diet and exercise: Encourage Darleene to maintain her current healthy diet.
- Increase physical activity: Recommend gradually increasing walking duration to 20-30 minutes daily to further support weight loss and overall health.
- Moderate alcohol intake: Discuss the potential negative impact of excessive alcohol consumption on blood pressure control. Darleene agrees to limit her wine intake to weekend evenings only as a trial to assess its effect on her BP.

2. Monitoring and follow-up:

- Home blood pressure (BP) monitoring: Instruct Darleene to monitor her BP regularly at home and maintain a diary to document the readings.
- Potassium level check: Schedule a blood test to assess her potassium level due to the potential electrolyte imbalance associated with diuretic use.
- Follow-up appointment: Schedule a follow-up clinic visit in one month. At this visit, Darleene should bring her BP diary for review. Based on her progress, blood pressure readings, and overall evaluation, the addition of an ACE inhibitor medication might be considered if BP remains uncontrolled.

SOAP note example for massage therapists

Subjective

Fred stated that it had been about one month since his last treatment. Fred stated that he "has been spending a lot more time on his computer" and attributes his increased tension in his upper back and neck to this. Currently, Fred experiences a dull aching 4/10 in his left trapezius area. He "would like a relaxation massage with a focus on my neck and shoulders."

Objective

Tenderness at the left superior angle of the scapula. Gross BUE and cervical strength. A full body massage was provided. TrPs at right upper traps and scapula. Provided client with education on posture when at the computer. Issued handouts and instructed on exercises. All treatment kept within Pt.

Assessment

Fred reported 1/10 pain following treatment. Good understanding, return demonstration of stretches and exercises—no adverse reactions to treatment.

Plan

To continue DT and TRP work on upper back and neck as required. Reassess posture and sitting at the next visit.