

Components of a SOAP Note in Occupational Therapy

Here's what goes into a SOAP note for occupational therapy.

S

Subjective: Gathering the Patient's Statements, Feelings and Perceptions

Here, you'll document the patient's personal experiences, feelings and perceptions about their therapy. It's about understanding the patient's perspective, concerns and how they're coping with challenges.

O

Objective: Documenting Measurable, Observable Data

This is your factual account of the therapy session. This includes documenting patient activities, their responses to various interventions, and your direct professional observations. It's a record of what was done, seen, and measured—like the patient's ability to perform certain tasks, their physical responses to treatment, and apparent range of motion when performing certain movements.

A

Assessment: Professional Interpretation of Subjective & Objective Information

Here, you'll examine the information gathered in the Subjective and Objective sections to make a professional judgment. This includes assessing the patient's progress, identifying any challenges or changes in their condition, and evaluating their response to therapy.

P

Plan: Detailing Future Therapy Plans, Adjustments in Treatment & Setting Goals

The Plan is the forward-looking component of the SOAP note. It outlines your recommendations for future therapy sessions, adjustments in treatment strategies, and sets short- and long-term goals for the patient.

Sample Occupational Therapy Soap Notes

**Kathleen A. Curtis, Peggy DeCelle
Newman**



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