SOAP Progress Notes

Patient information

Name: Emily Thompson

Age: 32   **Gender:** 05/12/1991   **Date of birth:** 05/12/1991

Subjective

Emily reports persistent headaches for the past two weeks, describing them as "throbbing pain" behind her eyes. She rates the pain as 7/10 at its worst, typically in the late afternoon. Emily mentions increased stress at work and difficulty sleeping. She has been taking over-the-counter ibuprofen with minimal relief. No visual disturbances or nausea reported. Patient denies any recent head injuries or changes in medication.

Objective

BP: 128/82 mmHg
HR: 76 bpm
Temp: 98.6°F (37°C)
Resp: 16/min
Weight: 145 lbs (65.8 kg)
Neurological exam: Alert and oriented x3, pupils equal and reactive to light, no focal deficits
Neck: Full range of motion, no lymphadenopathy
Sinuses: Nontender to palpation

Assessment

Tension headaches, likely related to increased stress and poor sleep hygiene. Differential diagnoses to consider: migraine without aura, cervicogenic headache, medication overuse headache.

Plan

Educate patient on stress management techniques and sleep hygiene
Recommend switch to acetaminophen 500mg q6h PRN for pain relief
Encourage adequate hydration and regular meals
Prescribe sumatriptan 50mg PO for severe headaches, max 2 doses/24 hours
Refer to physical therapy for neck stretches and posture assessment
Follow up in 2 weeks if symptoms persist or worsen
Consider referral to neurology if no improvement with current plan

Practitioner's name: Dr. Sarah Johnson

Practitioner's signature:

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Naijian Zhang,Richard D. Parsons

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<u>The Clinical Documentation Sourcebook</u> Donald E. Wiger,2005-03-04 All the forms handouts and records mental health professionals need to meet documentation requirements The paperwork required when providing mental health services continues to mount Keeping records for managed care reimbursement accreditation agencies protection in the event of lawsuits and to help streamline patient care in solo and group practices inpatient facilities and hospitals has become increasingly important This updated and revised Third Edition provides you with a full range of forms checklists and clinical records essential for effectively and efficiently managing your practice From intake to diagnosis and treatment through discharge and outcome assessment The Clinical Documentation Sourcebook Third Edition offers sample forms for every stage of the treatment process Greatly expanded from the second edition the book now includes twenty six fully completed forms illustrating the proper way to fill them out as well as fifty two ready to copy blank forms The included CD ROM also provides these forms in Word format so you can easily customize them to suit your practice With The Clinical Documentation Sourcebook Third Edition you ll spend less time on paperwork and more time with clients Includes documentation for child family and couples counseling Updated for HIPAA compliance as well as to reflect the latest JCAHO and CARF regulations New focus on clinical outcomes supports the latest innovations in evidence based practice **Modules for Basic Nursing Skills** Janice Rider Ellis,Elizabeth Ann Nowlis,Patricia M. Bentz,1992-01-01 **Clinical Pharmacy (2nd Edition)** Jeffery Hughes,2001-12-15 Clinical pharmacy a practical approach **Documentation for Rehabilitation** Lori Quinn,James Gordon,2015-12-11 Better patient management starts with better documentation Documentation for Rehabilitation A Guide to Clinical Decision Making in Physical Therapy 3rd Edition shows how to accurately document treatment progress and patient outcomes Designed for use by rehabilitation professionals documentation guidelines are easily adaptable to different practice settings and patient populations Realistic examples and practice exercises reinforce concepts and encourage you to apply what you ve learned Written by expert physical therapy educators Lori Quinn and James Gordon this book will improve your skills in both documentation and clinical reasoning A practical framework shows how to organize and structure PT records making it easier to document functional outcomes in many practice settings and is based on the International Classification for Functioning Disability and Health ICF model the one adopted by the APTA Coverage of practice settings includes documentation examples in acute care rehabilitation outpatient home care and nursing homes as well as a separate chapter on documentation in pediatric settings Guidelines to systematic documentation describe how to identify record measure and evaluate treatment and therapies especially important when insurance companies require evidence of functional progress in order to provide reimbursement Workbook textbook format uses examples and exercises in each chapter to reinforce your understanding of concepts NEW Standardized Outcome Measures chapter leads to better care and patient management by helping you select the right outcome measures for use in evaluations re evaluations and discharge

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