

# Components of a SOAP Note in Occupational Therapy

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



## **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.



## **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.



## **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.



## **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.

# Occupational Therapy Soap Note Examples

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