**As PT's (and other clinicians) we write SOAP notes:**

**S**= Subjective: This is what the patient tells you about their symptoms or past medical history.

**O**= Objective: This is what you observe or measure in your examination

**A**= Assessment: This is what you believe are the main issues and is a brief summary of the problem combined with your exam or treatment for that day

**P**= Plan: This is your recommendation and plan of action for treatment or future treatment.

**Here is a short version of a SOAP note just to become familiar with the format.**

S: Mr. Smith is a 65 y/o man who presents with complaints of pain in his left knee and difficulty walking after slipping and falling on ice.

O: Patient ambulates with an antalgic gait pattern and decreased knee extension.

     ROM: right knee is WNL (within normal limits), left knee flexion: 110 degrees, extension -10 deg.

     Left knee effusion is present while there is TTP (tenderness to palpation) over the distal insertion of the medial collateral ligament.  X-rays of left knee are negative.

A: Patient presents status-post acute sprain of the left MCL (medial collateral ligament).  He was treated with massage to decrease effusion, ROM, gait training to decrease compensatory pattern, cryotherapy (ice), and recommended to use RICE method as well as a home program of ROM and strengthening exercises.

P: Follow-up 2x/week for two weeks.

Clinician signature\_\_\_\_\_\_\_\_\_