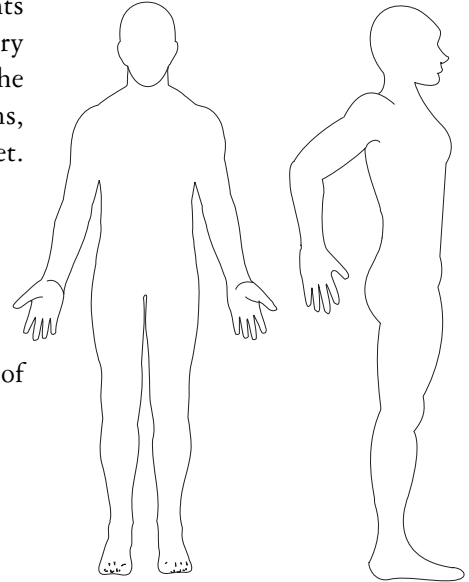


S.O.A.P. Notes

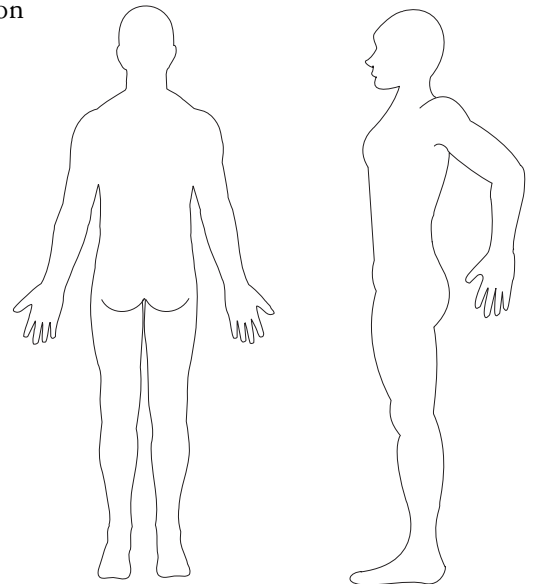
Name: _____ Date: _____

Subjective: A description of the symptoms and complaints discussed by the client (or the referring primary health care provider) that is inscribed using the client's own words. Key words are symptoms, locations, intensity, duration, frequency and onset.



Objective: An account of your observations and results of tests you administer.

Assessment: A record of the changes in the client's condition as a result of treatment.



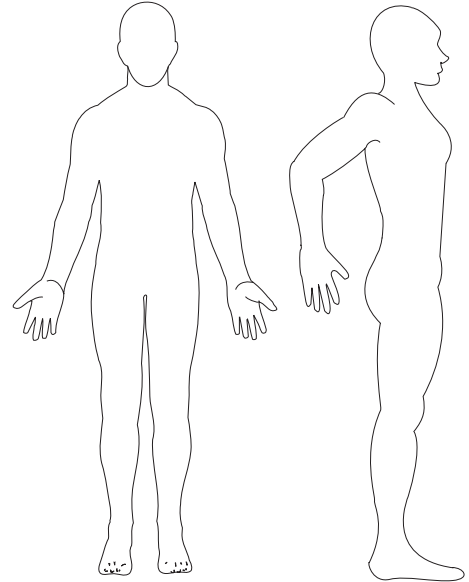
Plan: A list of recommended action.

Comments: _____

S.O.A.P. Notes

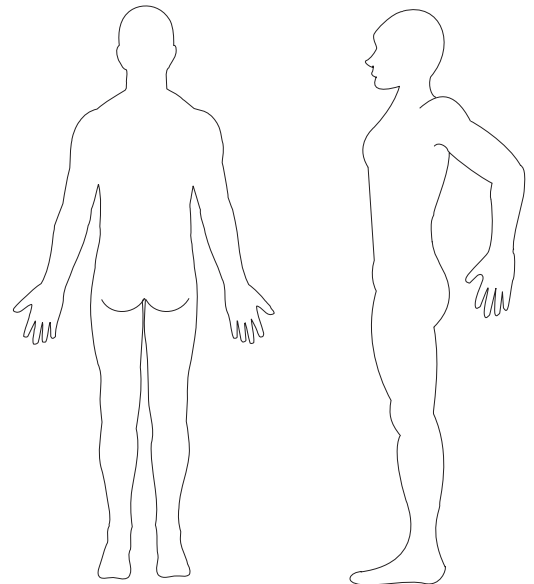
Name: _____ Date: _____

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Comments: _____

