# Outpatient Osteopathic SOAP Note

# Cranial Form Series

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# Table of Contents

# Usage Guide for Outpatient Osteopathic SOAP Note Form including Cranial

**Introduction:**

The following Outpatient Cranial SOAP Note Form was developed by the American Academy of Osteopathy's Louisa Burns Osteopathic Research Committee. This form is our recommendation to the Osteopathic Profession for general use, research and training, and includes osteopathy in the cranial field. Presently, the form is available for site-testing, with the intention that feedback from users will be the first step in validating and standardizing the form. *If, after using these forms, you have any comments on how to improve it, please refer them to the Louisa Burns Osteopathic Research Committee, 3500 De Pauw Blvd , Suite 1080, Indianapolis, IN 46268 This form will remain in its present version for the next year and will then be revised as indicated*

**Instructions for use:**

This form is especially designed for research purposes but also provides the most complete record of an office visit. Though this form provides a complete template for an established patient office visit, it can also be used for an initial visit or consultation, if the user feels sufficient space is provided. For office use, you might only wish to fill in the sections that would be most useful to you, but remember, those sections should support your method of patient care to any others who might review your records, including 3rd party payers. Print where stated. All printing or writing must be legible to anyone, otherwise the record is useless. Blacken the appropriate rectangles. If doing research, all sections critical to research data should be filled in. Data can be collected and analyzed by a computer. Additions to the form can be made. If data were not obtained for a certain section, leave it blank and that will signify that you did not gather that data. If the findings are negative, state that in order that it be known that the information was obtained. All definitions were obtained from the CPT book, the *Glossary of Osteopathic Terminology*, *Foundations for Osteopathic Medicine*, and Magoun's *Osteopathy in the Cranial Field*. The headings are presented and arranged as they appear on the form, beginning with the upper left-hand corner and reading to the right and down.

Regarding coding for billing office visits: We have chosen to not include information for coding on the form itself because, from time to time, the criteria for billing will change. Most practices have their own individual "charge slip" to accomplish this purpose. However, the Coding section at the end of this Usage Guide provides useful guidelines which are spelled out in even more detail in the 2005 Current Procedural Terminology (CPT) code book published by the American Medical Association. It is important to note that there are two different ways of selecting a level of Evaluation/Management (E/M) service. One was developed in 1995, which is more open to interpretation, and the other that was developed in 1997, which tends to be more restrictive, is based on number of "bulleted" items in various categories, and a point system for calculating complexity of medical decision-making. Although either method is acceptable for billing, we have chosen to describe the 1995 criteria, as that is more commonly used and is what is described in the 2005 CPT code book. For a detailed description of both criteria, one may reference the web site www.cms.hhs.gov/medlearn/emdoc.asp.

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***Page 1 of 2:***
**Subjective and Objective Data**
This page of the system identifies the patient, provides the **S** subjective portion of a SOAP note and begins to record **O** objective data including the usual physical examination items and general body symmetry.

**Section I: Identification**

**Patient's Name:** The first and last name of the patient and the date of this visit are recorded (month/day/year).

**Date:** Write in the date this initial summary was started. Use the following format for all dates: month/day/year.

**Age:** Write in the adult patient's age in years. If a child, use days up to 1 month, use months up to 1 year, and years (with or without fractions) of age for older.

**DOB—Date of Birth:** (month/day/year).

**The boxes** marked **Office of:** and **For office use only:** can be used for tracking a research study, for office record keeping, etc.

## Section II: Vital Signs

**S:** The Subjective section of the Cranial SOAP note begins here.

**Vital Signs:** Write in the corresponding vital signs on the lines provided. Three (3) of the seven (7) listed are needed to fulfill the requirements for a comprehensive examination. The seven include: 1. **Wt.** (weight in pounds, lbs), 2. **Ht.** (height in feet and inches, ft, in), 3. **HC.** (head circumference), 4. **Temp.** (temperature in degrees Fahrenheit or Centigrade) and indicate if it was taken O = oral, A = axillary or R = rectal), 5. **Resp.** (rate of respiration in breaths-per-minute) and whether it is easy or labored, 6. **Pulse** rate (in beats per minute) and whether it is regular (**Reg.**) or irregular (**Irreg.**), 7. **BP** (blood pressure) **Standing, Sitting, Supine.** If a measurement was not taken, leave its space blank.

## Section III: Chief Complaint, Location of the Complaint and Pain Scale

**CC** Stands for **Chief Complaint,** which is a concise statement describing the symptoms, the problem, condition, diagnosis or other factors that is the reason for the encounter. **CC** usually is stated in the patient's words.

**Patient's Pain Analog Scale:** The patient is asked to place a mark on the " NO PAIN-WORST POSSIBLE PAIN" analog scale indicating the degree of pain he/she has at the time of this interview. Patients are given the following instructions: "If you have **NO PAIN,** place a mark at the far left side. If this is the **WORST POSSIBLE PAIN** you have ever experienced, indicate it at the far right side. Indicate where your pain is at this time."

**AP and PA Figures** are provided along the right side of the form for the patient to indicate the location of their problem. The instructions stated are, "**Mark greatest problem areas.**" These figures can also be used by practitioner for demonstrating findings graphically.

## Section IV: HPI (History of Present Illness)

**History of Present Illness** (HPI): The HPI is a chronological description of the development of the patient's present illness, from the first sign and/or symptom to the present. This includes a description of **1** Location, **2** Quality, **3** Severity, **4** Duration, **5** Timing, **6** Context, **7** Mod. (modifying) factors, **8** Assoc. signs and symp., **9** Functional limitations, **10** Recent trauma and **11** Update since last seen. This is also the place to write any update from previous visits (eg, lab, X-ray, consultant or allied health professional input). Fill in all boxes and in the lines provided, write the number of the item and the details of that item for each element explored or history elicited. If desired, also write in any associated signs and symptoms significantly related to the presenting problem(s).

## Section V: ROS (Review of Systems)

**ROS** is an inventory of body systems, pertinent to the chief complaint, that are obtained through a series of questions seeking to identify signs and/or symptoms which the patient may be experiencing or has experienced. ROS is a guide for criteria needed to justify your evaluation and management CPT code in the subjective section. The following systems review have been identified: **1** Constitutional symptoms, **2** Eyes, **3** ENT(ears, nose and throat), **4** CV (cardio-vascular), **5** Resp. (respiratory), **6** GI (gastrointestinal), **7** GU (genito-urinary), **8** MS (musculoskeletal, **9** Integument, **10** Neuro (neurological), **11** Psych. (psychiatric), **12** Endo. (endocrine), **13** Hemo/lymph (hematologic/lymphatic), and **14** Allergic/imm. (allergic/immunologic) and for ***Peds*: 15** Feeding, **16** Development, **17** Sleep patterns, and **18** Behavior concerns. The review of systems helps define the problem, clarify the differential diagnoses, identify needed testing, or serves as baseline data on other systems that might be affected by any possible management options. Only fill in the box(s) of those systems reviewed at this encounter. Details of any system can be recorded by writing in its number and the details in the lines provided. If you examine a system and it is normal, fill in its rectangle and make no written comment about it.

## Section VI: PFSH (Past Medical, Family, Social History)

**PFSH** is a review of medical events in the patient's family that include significant information about: the health status or cause of death of parents, siblings, and children; specific diseases related to problems identified in the Chief Complaint or History of the Present Illness, and/or System Review; diseases of family that may be hereditary or place the patient at risk.

The items include: **1** Allergies: Yes or No, **2** Immunizations UTD? (up to date) Yes or No, **3** Fam. (family) History, **4** Soc. (social) History, **5** Surgeries, **6** Past history/trauma, **7** Hospitalizations, **8** Exposures: Yes or No, to smoke, pets, other; and for ***Peds*: 9** Birth history, **10** Immunizations (adults might also have this one checked), **11** School and **12** Caretaker. This section also asks for a list of present **Meds** (medications).

Only fill in the boxes of the items investigated. If an item is not investigated, do not fill in the box. If there is no significant finding for an investigated item, nothing more is needed. If there is a significant finding, write the number of the item and a brief description of the finding in the lines supplied.

**Social History** explores a review of age-appropriate past and current activities including significant information about: marital status and/or living arrangements; current employment; occupational history; family stresses, use of drugs, alcohol, and tobacco; level of education; sexual history; other relevant social factors.

**Trauma:** This is not only major trauma such a broken bones, car accidents etc. but also pratfalls, blows to the head etc., even if they did not seem to produce any noticeable after effects. This is because such minor traumas may upset the craniosacral mechanism and if not compensated naturally in time, they can produce many seemingly unrelated physical symptoms and dysfunctions.

**Birth History:** If this is explored and negative, fill in the box and no written explanation is needed. Explanations should be provided if there is history of prolonged labor, forceps delivery, poor Apgar score, birth trauma, respiratory distress, jaundice, etc.

**Caretaker:** This item is listed under **Peds** and indicates the person responsible for the care of the infant or child, presumably while a parent works. This is also the place to write if the child is in custody of only one or a non-biological parent. Specify the person's title such as mother, father, grandparent, social worker, foster parent etc. as is appropriate.

**Meds. (Medications):** If you inquired about the patient's present medications, fill in the rectangle preceding Meds. and then lists the medications being taken and their dosages. Also list the over-the-counter substances being taken such as herbs, health food substances, vitamins and homeopathic medicines. If medications were listed on one of your previous forms and there have been no changes since then, the No change rectangle could be blackened. If there are no medications taken, fill in the None rectangle. If new medications (including OTC drugs) are discovered, blacken the rectangle preceding **Meds:** and list the new medications and dosages.

Write any extra history that may be pertinent to the history and not listed in this section. If, for some reason, no PFSH history was obtained, then write "Not done" on a blank line in this section.

## Section VII: PE (Physical Examination)

**O**: The Objective section of the SOAP Note. Of course the **Vital Signs** of Section II on this page are a part of the physical findings.

This section explores **1** General appearance, **2** CV (cardiovascular system) by observe (observation), palp. (palpation), and/or (auscultation), **3** Coordination, **4** Sensation, **5** Orientation in time, person, place, alertness, and activity, **6** Mood, **7** Skin, **8** Reflexes, **9** Motor strength, **10** Cranial nerves, **11** Eyes, **12** ENT (ears, nose, throat), **13** Pulm. (pulmonary), **14** GI (gastro-intestinal), **15** GU (genitourinary), **16** Endo. (endocrines), **17** Head, and **18** Lymph.

Only fill in the boxes of the items investigated. If an item is not investigated, do not fill in the box. If there is no significant finding for an investigated item, nothing more is needed. If there is a significant finding, write the number of the item and a brief description of the finding in the lines supplied.

**Horizontal Planes and Body Fascial Pattern (Diagrams):** This section also includes two figures located near the right hand margin. The first figure can be used to indicate levelness of horizontal Landmarks, such as mastoid processes, shoulders, inferior angle of the scapula, iliac crests, inferior level of the PSISs, and the superior border of the greater trochanters. If a plane is level, the middle rectangle for that plane is blackened. If one side of a horizontal plane is depressed, the rectangle on that side is blackened. (This same diagram can also be used to denote such things as lateral curvatures, the PA weight bearing line, or any other documentation that may be helpful.)

The second figure is for recording the rotational preference of the four major regional, junctional, transitional Fascial Planes (OA, cervicothoracic, thoracolumbar, and lumbosacral regions). If a region has a rotational preference, the rectangle indicating the preference is blackened. If the fascial pattern for a region is ideal (rotates easily in both directions), the middle rectangle is blackened for that region.

## Section VIII: Gen. (general) Symmetry

**Body Type:** Determine if the patient's the body type is Endo. (endomorphic—thin), Meso. (mesomorphic—muscular), or Ecto. (ectomorphic—soft, round). Blacken the appropriate rectangle

**Posture:** Indicate if posture is Excellent, Fair, or Poor and whether it was assessed with the patient standing or seated. Blacken the appropriate rectangles.

**Gait/Crawl:** Observe the gait and/or the crawl and classify as Symmetrical or Asymmetrical. Blacken the appropriate rectangle.

**Short Leg:** Judge if the leg lengths are E (equal), or if one leg is short indicate that it is the L (left) or the R (right) leg and blacken the appropriate rectangle or write in your own measurement.

**AP Curves:** This item is for recording examination of the Cerv. (cervical) lordosis, and/or Thor. (thoracic) kyphosis, and/or Lumb. (lumbar) Lordosis AP Curves and whether they are **I** (increased), **N** (normal), or **D** (decreased). Blacken the appropriate rectangles.

**Lateral Curves (scoliosis):** ***Note: Indicate the convexity of the lateral curve that is present, not the direction of sidebending.*** This item is for recording examination of the Cerv. (cervical), and/or Thor. (thoracic), and/or Lumb. (lumbar) Lateral Curves (scoliosis) and whether they are L (left), R (right), Struc. (structural), or Func. (functional); and then if they are Md. (mild), Mod (moderate), or Sev. (severe). Blacken the appropriate rectangles.

**Standing Flexion and Seated Flexion Tests (FT):** The Standing Flexion Test (FT) and the Seated FT are conducted as described in *Foundations of Osteopathic Medicine*, Second Edition, Table 44.3, page 651. The tests are recoded as being Positive, R (right), L (left), or Negative. Blacken the appropriate rectangles.

## Section IX: Signatures

**Signature of examiner:** Signature of the attending physician is mandatory. Also, the transcriber should sign, if this is appropriate.

*Page 2 of 2:*
**Objective Musculoskeletal Examination, Assessment, and Plan of Treatment :**

The **O** objective musculoskeletal examination is continued from page 1 recordings of objective findings. This is followed by the **A** assessment and **P** plan for completion of the Cranial SOAP note form. This second page includes an evaluation of the head (cranium), and face (according to osteopathy in the cranial field). It is followed by the examination of the musculoskeletal system (type of exam, severity, somatic dysfunction found, whether OMT was given, type of OMT and the patient's response for each examined region of the body. It also provides for the determination of **Predominant level of Findings and treatment,** the **Key Dysfunction/Mechanisms,** the physician's **Evaluation of the patient prior to treatment, A** (assessment), **P** (plan for treatment), the **Minutes spent with the patient** and **Follow-up** time **Units.**

## Section I: Head and Face

**Asymmetry: 1. Asymmetry** No or Yes. If there is no asymmetry blacken the No rectangle. If there is asymmetry, blacken the Yes rectangle and then

indicate whether it is asymmetry of **2. Shape, 3. Orbits, 4. Ears, 5. Mandible,** or **6. Palate**. Blacken the appropriate rectangles. An additional blank line is available for writing in any further description indicated regarding these. If this is done, indicate the number of the described item.

**CRI** (cranial rhythmic impulse) / **PRM** (primary respiratory mechanism): Its Amplitude, Vitality and Rate are judged as being Low, Med. (medium), or High. The value or range for each of these is as follows:

Amplitude is difficult to quantify. Just as an arterial pulse can be described as being thready, normal or bounding, the CRI is the palpable excursion/abundance of the CRI. With experience the normal (medium) amplitude can be established. The physician then senses if the amplitude is lower or higher than normal (medium).

Vitality: is also difficult to quantify. Vitality can be thought of as forming a bell curve. With experience the physician quantifies normal vitality (the medium range) and senses if the vitality is lower or higher than usual.

Rate: note the actual rate as complete cycles per minute or categorized from the literature as follows:
Low: at or below 5 cycles/min
Med.: 6-11 cycles/min
High: at or above 12 cycles/min

**Severity of Dysfunction:** Any of the cranial regions listed may be examined. If no dysfunction is found in a region the **0** rectangle is blackened. If left or right dysfunction is found in a region it is graded as **1** (Mild), **2** (moderate), or **3** (severe) and the rectangle is blackened in the appropriate left or right column.

**OMT**: If OMT is given to the dysfunction of a region, blacken the rectangle for that region.

**Anterior** includes SS (sphenosquamous), PS (petrosphenoid), FS (frontosphenoid), FrC (intraosseous compression of frontal), Fac (facial bones), and, Man (mandible).

**Posterior** includes OA (occipitoatlantal), Tn (tentorium cerebelli), PJ (petrojugular), PT (petrotemporal), OcC (occipital condylar compression), OM (occipitomastoid). La (lambdoid), and TMJ (temporomandibular joint).

**Coronal** relates to the relation (balance) of each side of this suture to each of the parietal bones and each side of the frontal bone. A grade of 0 for dysfunction would mean there is good balance at all of these regions along the coronal suture.

**Midline** includes Flx (falx), Sag. (sagittal), Eth (ethmoid), (Vom or vomer—not listed). The anterior and posterior of this region is examined. If dysfunction is found it is graded 0-3 in **Severity** in the appropriate section and blacken the rectangle if **OMT** was given

**Temporal** includes TmC (intra-osseous temporal compression) This region is examined to see if there is a preference for **Int.** (internal) **rotation** or **Ext.** (external) **rotation**. If **OMT** was given, blacken the appropriate rectangle.

**Sphenobasilar (SBS) Strain Patterns:** The cranial rhythm pattern may be examined for the following sphenobasilar symphyseal strain patterns:

**Sidebend/rotation,** or **Torsion,** or **Lateral strain:** The cranium is examined for each of these patterns. Sidebending/rotation is named for the side that is low and convex; Torsion is named for the side of the high sphenoid wing; Lateral strain is named for the position of the basisphenoid in relation to the basiocciput. Each of these are diagnosed as being N (normal or not present) or with dysfunction and also named as **L** (left) or **R** (right). The appropriate rectangles are blackened. If **OMT** was given to any of these dysfunctions, that appropriate rectangle is also blackened.

**Vertical strain:** is named for the named for the position of the basisphenoid in relation to the basiocciput. It is diagnosed as being **N** (not present), **S** (superior), or **I** (inferior). If **OMT** were given that rectangle is also blackened.

**Flexion,** or **Extension,** or **SBS comp.** (compression): The cranium is examined for these strain patterns If a preferences for one of these is not found the rectangle for **N** (normal) is blackened. If one of these preferences is found the rectangle **Y** (yes) is blackened. If **OMT** were given the appropriate rectangle is blackened.

**Type of** (cranial) **OMT Used:** The types of cranial OMT that was given to the head region is indicated by blackening the appropriate rectangles:

| | |
|---|---|
| BMT: | Balanced membranous tension |
| CV4: | Compression of the 4th ventricle |
| DIR: | Direct method |
| Aug: | Augmentation |
| Dis: | Disengagement |
| Mol: | Molding |
| Exag: | Exaggeration |
| OPM: | Opposite physiologic motion |
| Ven Sin: | Venous sinus drainage technique |
| Other: | Any other OMT treatment used |

**Response:** Resolved, Improved Unchanged, or Worse. Blacken the appropriate triangles.

**Section II: Musculoskeletal Table**

**Methods Used for Examination:** Be sure to blacken in the rectangles indicating the tools used for your examination (**T, A, R, T**). Included in the definition of these components are the criteria required for coding in each body area.

| | |
|---|---|
| **All:** | Indicates that all **TART** criteria were used to examine a region. |
| **T:** | **Tissue Texture Change,** stability, laxity, effusions, tone. |
| **A:** | **Asymmetry,** misalignment, crepitation, defects, masses. |
| **R:** | **Range-of-Motion,** contracture. |
| **T:** | **Tenderness,** pain. |

Filling in these squares is a shortcut to a full narrative documentation in the **Somatic Dysfunction** (and other systems) section of this table.

**Region Evaluated:** This is a list of musculoskeletal body regions include: ***1. Head and Face** (see Section I of page 2 of 2), ***2. Neck**; ***3.** The spine (**Thoracic, Ribs, Lumbar, Sacrum/Pelvis, Pelvis/Innom.** and **Abd.**, (abdomen) **Dia.** (diaphragm)**/Other**); ***4. Left Upper Extremity**; ***5. Right Upper Extremity**; ***6. Left Lower Extremity**; and ***7. Right Lower Extremity**. The thoracic region and ribs are broken down into three parts based on vertebral levels for innervation specificity: **T1-4**, **T5-9**, and **T10-12**. This provides for ease in listing interrelationships between musculoskeletal findings and possible involvement of the visceral system.

*Note: Junctional regions of the spine are "rounded up" to the superior region. I.e., OA is included in the occipital region, cervicothoracic junction in the cervical region, the thoracolumbar junction in the thoracic region, and the lumbosacral region in the lumbar region*

**Severity:** This section refers L. (left) Severity or R. (right) Severity as [None (**0**), mild (**1**), moderate (**2**), severe (**3**)] of the most affected somatic dysfunction in a region. Fill in the appropriate rectangle for each region examined.

If a rectangle is **not marked** in a region, it is assumed that that region was **not examined**. For regions that are examined, the scale is as follows:

| | |
|---|---|
| **0** None | No somatic dysfunction present or background (BG) level. |
| **1** Mild | More than background, minor **TART** elements. |
| **2** Moderate | Obvious **TART**; in particular **R**ange-of-motion (**R**) and/or **T**issue texture change (**T**) may or may not be overtly symptomatic. |
| **3** Severe | Key lesions observed, significant, symptomatic, stands out; **R** and/or **T** elements stand out with minimum search or provocation. |

**Somatic Dysfunction:** Somatic Dysfunction is defined as impaired or altered function of related components of the somatic (body framework) system: skeletal, arthrodial, and myofascial structure, and related vascular, lymphatic, and neural elements. If you filled in rectangles under **TART** you do not need to write anything here for coding purposes; however, this section is useful for recording notes for personal review or describing important dysfunctions found in other systems, the abdominal diaphragm, thoracic inlet, pelvic diaphragm, etc.

In this section for each region assessed, you may write your somatic dysfunctions, including musculoskeletal (MS), sympathetic nervous system (SNS), parasympathetic nervous system (PNS), lymphatic (LYM), cardiovascular (CV), respiratory (RESP), gastrointestinal (GI), fascial

(FAS), etc., components. Use standard terminology.

**OMT** (Osteopathic Manipulative Treatment): Blacken any rectangle of a region in which OMT was given. This would only be a region which was examined and a severity was recorded. However, it is possible that for some reason a somatic dysfunction was found but OMT was not indicated or performed at the time of this examination so, the rectangle for OMT of that region's somatic dysfunction would be left blank.

**Type OMT Used:** Circle any of the manipulative techniques used to treat any of the regions of the spine, sacrum or extremities.

- **Art:** articulatory treatment.
- **BLT:** balanced ligamentous tension / ligamentous articular strain treatment.
- **BMT:** Balanced membranous tension
- **CS:** counterstrain treatment.
- **DIR:** direct treatment.
- **FPR:** facilitated positional release treatment.
- **HVLA:** high velocity/low amplitude treatment (thrust treatment).
- **IND:** indirect treatment.
- **INR:** integrated neuromuscular release.
- **LAS:** ligamentous articular strain / balanced ligamentous tension treatment.
- **ME:** muscle energy treatment.
- **MFR:** myofascial release treatment.
- **ST:** soft tissue treatment
- **VIS:** visceral manipulative treatment.
- **OTH:** e.g. Per (percussion hammer), Aug (augmentation)

**Response:** Fill in one of these rectangles for each region of somatic dysfunction that was treated with OMT. This is the physician's perception of how the somatic dysfunctions in each region responded to Osteopathic Treatment immediately after treatment. The rectangles are indicated as follows:

- **R:** The somatic dysfunction is completely Resolved without evidence of it ever having been present.
- **I:** The somatic dysfunction is Improved but not completely resolved.
- **U:** The somatic dysfunction is Unchanged or the same after treatment as it was before treatment.
- **W:** The somatic dysfunction is Worse or aggravated immediately after treatment.

**Predominant level of findings and treatment:** This is to indicate if the findings and the treatment concentrated mainly on the level of the Bones, Fascia/Dura, Fluid, CNS (central nervous system), or Embryonic axis. Blacken the appropriate rectangle or rectangles.

The Embryonic axis is a description using an embryologic pathway of development (as referenced from the midline) as a guide for determining presence of somatic dysfunction

**Evaluation of patient prior to treatment:** Determine if this is the patient's **First visit**, or a subsequent visit at which time the patient's original condition was **Resolved, Improved, Unchanged**, or **Worse**. Blacken the appropriate rectangle

## Section III: A Assessment

**Dx No.** (diagnosis priority number) Columns one, three and five, are **Dx #** columns for assigning priority numbers of importance, with "1" being the number of the most severe or most addressed diagnosis present in this visit. A graded priority number would be assigned to each written diagnosis or before each region where a somatic dysfunction of a sprain or strain was found.

**Written Dx** (diagnosis): In column two write in any diagnosis such as medical, emotional, or social. Somatic dysfunctions can be circled in column four and strains/sprains can be circled in column six. Be sure to include consideration of all of these columns of diagnoses when prioritizing your Dx (diagnostic) No. (numbers).

## Section IV: P Plan of Treatment

**1 Meds:** If medications are prescribed, blacken the rectangle, then put number 1 on a blank line and list the meds and dosages. Keep a copy of your Rx. Risks, benefits, and potential side effects that you want to check for in future visits can be listed here.

**2 OMT:** If OMT had been included in the plan blacken its rectangle and indicate when to be seen for this again.

**3 Exercise:** List in this space any exercises you wish the patient to continue or add to their treatment prescription and whether they were discussed, taught, or given as handouts. If exercises are prescribed, blacken the rectangle, then put number 3 on a blank line and list the exercises recommended.

**4 Nutrition:** If any nutritional advice, food, or diet recommendations were given to the patient, blacken this rectangle. Then put number 4 on a blank line describe your recommendations.

**5 X-ray:** If x-rays are ordered blacken this rectangle. Then put number 5 on a blank line and list the x-rays that were ordered and in which facility if there are many radiology departments in the community or nearby region.

**6 PT**(physical therapy)**:** If physical therapy is ordered blacken this rectangle. Then put number 6 on a blank line and list the Physical Therapy modalities your patient currently receives, has received in the office, or that you recommend they receive or perform.

**7 Lab:** If lab tests are ordered blacken this rectangle. Then put number 7 on a blank line and List any lab tests ordered and the site of the laboratory if there are many in the community or surrounding region or it is the test is to be sent to a special lab in another city.

**8 Consult:** If a consultation is recommended blacken this rectangle. Then write number 8 on a blank line and write the name and specialty of the consultant (and date of the consult, if this is known).

**9 Instructions:** If there are special instruction given blacken this rectangle. Write number 9 on a blank line and list the instruction(s).

**10 Other:** This is for anything that does not fit into any of the other categories. If some other type of treatment or consideration was provided, blacken this triangle. Write number 10 and describe it. For example, if 50% or more of your time was spent with the patient was counseling or educating the patient, specifically list topics discussed, the details that were included, handouts or educational materials given.

**Minutes Spent With the Patient:** Blacken the rectangle that corresponds to the amount of time you spent face-to-face with the patient and/or family during their visit (10, 15, 25, 40, 60, >60 minutes). Choose the rectangle that best fits your total time.

**Follow-up and Units:** Blacken the rectangles that correspond to when you would like to see the patient again; you must indicate both the number and the **Units**. For example: for a visit in one month, blacken the rectangle above the "**1**" and also the rectangle above **M** (month). Abbreviations following the **Units** title are: **D** (days), **W** (week), **Y** (year), and **PRN** (as needed).

**Section V: Signature of the Examiner:** Signature of the attending physician is mandatory. Also, the transcriber should sign, if this is appropriate.

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## Coding

If you bill for **outpatient** evaluation and management (E/M) services, use a 5 digit code that signifies the level of service you have given. The codes:

**NEW PATIENTS**, range from **992*01*-992*05***
**ESTABLISHED PATIENTS** range from **992*11*-992*15***.
**OUTPATIENT CONSULTATIONS (for new or established patients)** range from **99241-992*45***.

**THE MAIN COMPONENTS THAT DETERMINE THE LEVEL OF E/M SERVICES** are detailed in the following areas:

1. **History**
2. **Examination**
3. **Complexity of medical decision-making**
4. **Other Factors** including:
   **Counseling**
   **Coordination of care**
   **Nature of the presenting problem**.

   ***Note: When counseling and/or coordination of care dominates more than 50% of the office call, time becomes the key controlling factor. The time and the counseling and/or coordination of care must be documented in the patient's chart.***

**DETERMINING THE EXTENT OF THE HISTORY OBTAINED** The level of history is determined by its content:

***Problem-focused***: chief complaint; brief history of present illness or problem
***Expanded problem-focused***: chief complaint, brief history of present illness; problem pertinent system review
***Detailed***: chief complaint; extended history of present illness; problem pertinent system review extended to include a review of limited number of additional systems; **pertinent** past, family, and/or social history **directly related to the patient's problems**
***Comprehensive***: chief complaint; extended history of present illness; review of systems which is directly related to the problem(s) identified in the history of present illness plus a review of all additional body systems; **complete** past, family, and social history.

**DETERMINING THE EXTENT OF THE EXAMINATION PERFORMED** The level of examination is determined by extent of the examination—what was actually examined and documented:

***Problem-focused:*** a limited examination of the affected body area or organ system
***Expanded problem-focused***: a limited examination of the affected body area organ system and other symptomatic or related organ system(s)
***Detailed***: an extended examination of the affected body area(s) and other symptomatic or related organ system(s)
***Comprehensive***: a general multi-system examination or a complete examination of a single organ system.

**DETERMINING THE COMPLEXITY OF MEDICAL DECISION-MAKING** is categorized as:

***Straightforward***
***Low complexity***
***Moderate complexity***
***High Complexity***

This Complexity of Medical Decision-Making category involves the complexity of establishing a diagnosis and/or selecting a management option that is measured by **at least two of the three** following elements:

***The number*** of **possible diagnoses** and/or the number of **management options** that must be considered (minimal, limited, multiple, or extensive)
***The amount and/or complexity*** of **medical records, diagnostic tests**, and/or other **information** that must be obtained, reviewed, and analyzed, (minimal or none, limited, moderate, or extensive) and
***The risk*** of **significant complications, morbidity** and/or **mortality**, as well as **comorbidities**, associated with the patient's presenting problem(s), the diagnostic procedure(s), and/or the possible management options (minimal, low, moderate, or high)

**CHOICE OF EVALUATION AND MANAGEMENT (E/M) CODE LEVEL:** (These charts are useful in establishing the appropriate E/M level)

*NEW PATIENT*:[1] **All three key components** (history, examination, and complexity) **must meet or exceed the level** described to qualify for a particular E/M service.

| **HISTORY** | Problem-focused: | Expanded problem-focused: | Detailed: | Comprehensive: | Comprehensive: |
|---|---|---|---|---|---|
| **EXAM** | Problem-focused | Expanded problem-focused: | Detailed: | Comprehensive | Comprehensive |
| **DECISION MAKING** | Straightforward | Straightforward | Low complexity | Moderate complexity | High Complexity |
| **CODE** | **99201** | **99202** | **99203** | **99204** | **99205** |

*ESTABLISHED PATIENT*: **Two of the three key components** must meet or exceed the level described.

| **HISTORY** | N/A | Problem-focused: | Expanded problem-focused: | Detailed: | Comprehensive: |
|---|---|---|---|---|---|
| **EXAM** | N/A | Problem-focused | Expanded problem-focused: | Detailed: | Comprehensive: |
| **DECISION MAKING** | N/A | Straightforward | Low complexity | Moderate complexity | High Complexity |
| **CODE** | **99211** | **99212** | **99213** | **99214** | **99215** |

**USING TIME FOR CODING:**

When **time** is the determining factor of the E/M level of service: These are the general guidelines that have been established for length of time usually associated with each E/M level, for both new patients (10, 20, 30, 45, or 60 minutes) and established patients (5, 10, 15, 25, or 40 minutes). This is generally a reflection of face-to-face time with the patient.

When the time spent on a patient is beyond 30 minutes or more than is expected for the level of complexity for the established E/M, the code **99354** is used in addition to the E/M code. Then, for each additional 30 minutes beyond the first hour, *an additional* code **99355 (x1, 2, 3, or 4)** is added.

**CODING FOR OMT SERVICES:**

If the patient's condition requires a significant separately identifiable E/M service that is above and beyond the usual pre-service and post-service work associated with the procedure (OMT), the physician may choose to charge separately for the OMT and for the evaluation and management visit.

[1] A new patient is also a patient that has not been seen in the last 3 years.

Different diagnoses are not required for reporting of the E/M services on the same date, though the diagnostic codes (**739.0-739.9**) for somatic dysfunction in various regions (including head, cervical, thoracic, lumbar, sacral, pelvic, lower extremities, upper extremities, rib cage, and abdomen/viscera) are usually utilized.

The E/M coding should be reported with a modifier **"25"** following the E/M level. Charges for OMT are based on the number of areas treated, and the procedures are coded as one of these five, **98925-98929,** representing treatment to 1-2, 3-4, 5-6, 7-8, or 9-10 body regions.

Third party reimbursement for these separate services varies considerably. Contact the American Academy of Osteopathy (www.academyofosteopathy.org) and/or the American Osteopathic Association (www.osteopathic.org) for assistance in dealing with complications associated with coding and billing for OMT services.

# Outpatient Osteopathic SOAP Note Form including Cranial

*wak CRANIAL SOAP version 5.120904*

Name _____ Date _____

Age _____ DOB _____

| Office of: | For office use only: |
|---|---|
| | |

**S** ***Vital Signs*** Wt _____ Ht _____ HC _____ Temp _____ ▯ O ▯ A ▯ R

2 Resp. _____ ▯ Easy ▯ Labored Pulse _____ Reg.▯ Irreg. ▯ BP _____/_____ Seated ▯ Standing ▯ Supine ▯

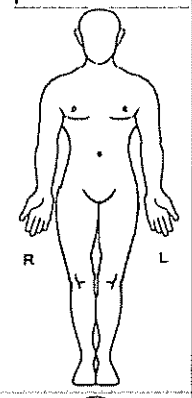
**CC: What is your main problem today?** _____

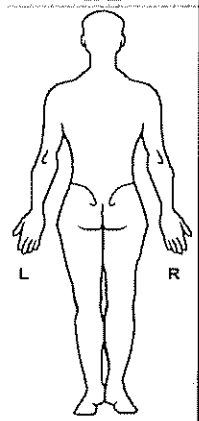
**Please mark your average, recent pain level on the scale below:**

**NO PAIN** **WORST POSSIBLE PAIN**

4 **HPI:** 1 ▯ Location, 2 ▯ Quality, 3 ▯ Severity, 4 ▯ Duration, 5 ▯ Timing, 6 ▯ Content, 7 ▯ Mod factors, 8 ▯ Assoc signs and symp 9 ▯ Functional limitations, 10 ▯ Recent trauma, 11 ▯ Update since last seen

**Mark greatest problem areas**




5 **ROS:** 1 ▯ Constitutional, 2 ▯ Eyes, 3 ▯ ENT, 4 ▯ CV, 5 ▯ Resp , 6 ▯ GI, 7 ▯ GU, 8 ▯ MS, 9 ▯ Integument , 10 ▯ Neuro, 11 ▯ Psych, 12 ▯ Endo , 13 ▯ Hemato/lymph, 14 ▯ Allergic / imm
***Peds:*** 15 ▯ Feeding, 16 ▯ Development, 17 ▯ Sleep patterns, 18 ▯ Behavior concerns.

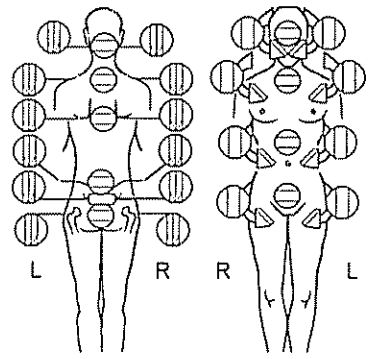
6 **PFSH:** 1 ▯ Allergy: ▯ Yes ▯ No, 2 ▯ Immunization UTD? ▯ Yes ▯ No, 3 ▯ Fam. history, 4 ▯ Soc. history, 5 ▯ Surgeries, 6 ▯ Past history/trauma, 7 ▯ Hospitalizations, 8 Exposures: ▯ Yes ▯ No, ▯ smoke, ▯ pets, ▯ other _____ ***Peds:*** 9 ▯ Birth history, 10 ▯ Immunizations, 11 ▯ School, 12 ▯ Caretaker

| ▯ **Meds:** ▯ No change ▯ None | |
|---|---|
| | |

**O**

**PE:** 1 ▯ General appearance, 2 CV: ▯ observe ▯ palp ▯ auscultate, 3 ▯ Coordination, 4 ▯ Sensation, 5 Orientation: ▯ time ▯ person ▯ place ▯ alertness ▯ activity, 6 ▯ Mood, 7 ▯ Skin, 8 ▯ Reflexes, 9 ▯ Motor strength, 10 ▯ Cranial nerves, 11 ▯ Eyes, 12 ▯ ENT, 13 ▯ Pulm., 14 ▯ GI, 15 ▯ GU, 16 ▯ Endo., 17 ▯ Head, 18 ▯ Lymph.

7




Landmarks Fascial Planes

8 **Gen. Symmetry:** 1 ▯ Body Type: ▯ Endo., ▯ Meso., ▯ Ecto., 2 Posture: ▯ Excellent ▯ Fair ▯ Poor, ▯ Standing, ▯ Seated.

3 Gait /Crawl: ▯ Symmetrical, ▯ Asymmetrical, 4 "Short Leg:" ▯ E ▯ L ▯ R ▯ 1/8 inch ▯ 1/4 inch ▯ 1/2 inch _____

5 AP Curves: Cerv. lordosis: ▯ I, ▯ N, ▯ D 6 Lat. Curves—Cerv. ▯ L ▯ R ▯ Struc. ▯ Func. ▯ Md ▯ Mod ▯ Sev.

Thor. kyphosis: ▯ I, ▯ N, ▯ D (scoliosis): Thor. ▯ L ▯ R ▯ Struc. ▯ Func. ▯ Md. ▯ Mod ▯ Sev.

Lumb. lordosis: ▯ I, ▯ N, ▯ D Lumb. ▯ L ▯ R, ▯ Struc. ▯ Func. ▯ Md. ▯ Mod ▯ Sev.

7 Standing Flexion Test (FT): ▯ Positive ▯ R ▯ L, ▯ Negative 8 Seated FT: ▯ Positive ▯ R ▯ L, ▯ Negative

9 Signature of Transcriber: Signature of Examiner:



*Designed in Coordination with Outpatient Osteopathic SOAP Note Forms*

# Outpatient Osteopathic SOAP Note Form
## Including Cranial (continued)

Name _____ Date _____

**O** Head and Face: 1 Asymmetry: ☐ No ☐ Yes, 2 ☐ Shape, 3 ☐ Orbits, 4 ☐ Ears, 5 ☐ Mandible, 6 ☐ Palate.

CRI/PRM Amplitude: ☐ Low ☐ Med. ☐ High | Vitality: ☐ Low ☐ Med. ☐ High | Rate: ☐ Low ☐ Med. ☐ High

| Severity of Dysfunction | | 0 1 2 3 | | 0 1 2 3 | OMT | Notes | SBS Strain Patterns | | OMT |
|---|---|---|---|---|---|---|---|---|---|
| Anterior (SS PS FS FrC, Fac, Man) | L | ☐ ☐ ☐ ☐ | R | ☐ ☐ ☐ ☐ | ☐ | | Sidebend/rotation | ☐ N ☐ L ☐ R | ☐ |
| Posterior (OA, Tn PJ PT, OcC, OM, La, TMJ) | L | ☐ ☐ ☐ ☐ | R | ☐ ☐ ☐ ☐ | ☐ | | Torsion | ☐ N ☐ L ☐ R | ☐ |
| Coronal | L | ☐ ☐ ☐ ☐ | R | ☐ ☐ ☐ ☐ | ☐ | | Lateral strain | ☐ N ☐ L ☐ R | ☐ |
| Midline (Fix Sag Eth) | A | ☐ ☐ ☐ ☐ | P | ☐ ☐ ☐ ☐ | ☐ | | Vertical strain | ☐ N ☐ S ☐ I | ☐ |
| Temporal (TmC) | L | ☐ Y ☐ N | R | ☐ Y ☐ N | ☐ | | Flexion | ☐ N ☐ Y ---- | ☐ |
| Int. rotation | L | ☐ Y ☐ N | R | ☐ Y ☐ N | ☐ | | Extension | ☐ N ☐ Y ---- | ☐ |
| Ext. rotation | L | ☐ Y ☐ N | R | ☐ Y ☐ N | ☐ | | SBS comp | ☐ N ☐ Y ---- | ☐ |

OMT Used: ☐ BMT ☐ CV4, ☐ DIR, ☐ Aug, ☐ Dis, ☐ Mol, ☐ Exag, ☐ OPM, ☐ Ven Sin, ☐ OTH. Response ▶ ☐ R ☐ I ☐ U ☐ W

**2**

| Methods Used All T A R T | Other Regions Evaluated | L. Severity 0 1 2 3 | R. Severity 0 1 2 3 | Somatic Dysfunction MS / SNS / PNS / LYM / CV / RESP / GI / FAS / etc | OMT | Type OMT Used | Response R | I | U | W |
|---|---|---|---|---|---|---|---|---|---|---|
| ☐ ☐ ☐ ☐ ☐ | Neck | ☐ ☐ ☐ ☐ | ☐ ☐ ☐ ☐ | | ☐ | ART | ☐ | ☐ | ☐ | ☐ |
| ☐ ☐ ☐ ☐ ☐ | Thoracic T1-4 | ☐ ☐ ☐ ☐ | ☐ ☐ ☐ ☐ | | ☐ | BLT | ☐ | ☐ | ☐ | ☐ |
| ☐ ☐ ☐ ☐ ☐ | T5-9 | ☐ ☐ ☐ ☐ | ☐ ☐ ☐ ☐ | | ☐ | BMT | ☐ | ☐ | ☐ | ☐ |
| ☐ ☐ ☐ ☐ ☐ | T10-12 | ☐ ☐ ☐ ☐ | ☐ ☐ ☐ ☐ | | ☐ | CS | ☐ | ☐ | ☐ | ☐ |
| ☐ ☐ ☐ ☐ ☐ | Ribs 1-4 | ☐ ☐ ☐ ☐ | ☐ ☐ ☐ ☐ | | ☐ | DIR | ☐ | ☐ | ☐ | ☐ |
| ☐ ☐ ☐ ☐ ☐ | 5-9 | ☐ ☐ ☐ ☐ | ☐ ☐ ☐ ☐ | | ☐ | FPR | ☐ | ☐ | ☐ | ☐ |
| ☐ ☐ ☐ ☐ ☐ | 10-12 | ☐ ☐ ☐ ☐ | ☐ ☐ ☐ ☐ | | ☐ | HVLA | ☐ | ☐ | ☐ | ☐ |
| ☐ ☐ ☐ ☐ ☐ | Lumbar | ☐ ☐ ☐ ☐ | ☐ ☐ ☐ ☐ | | ☐ | IND | ☐ | ☐ | ☐ | ☐ |
| ☐ ☐ ☐ ☐ ☐ | Sacrum/Pelvis | ☐ ☐ ☐ ☐ | ☐ ☐ ☐ ☐ | | ☐ | INR | ☐ | ☐ | ☐ | ☐ |
| ☐ ☐ ☐ ☐ ☐ | Pelvis/ Innom. | ☐ ☐ ☐ ☐ | ☐ ☐ ☐ ☐ | | ☐ | LAS | ☐ | ☐ | ☐ | ☐ |
| ☐ ☐ ☐ ☐ ☐ | Abd,, Dia / Other | ☐ ☐ ☐ ☐ | ☐ ☐ ☐ ☐ | | ☐ | ME | ☐ | ☐ | ☐ | ☐ |
| ☐ ☐ ☐ ☐ ☐ | Upper Extrem. | ☐ ☐ ☐ ☐ | ☐ ☐ ☐ ☐ | | ☐ | MFR | ☐ | ☐ | ☐ | ☐ |
| ☐ ☐ ☐ ☐ ☐ | Lower Extrem. | ☐ ☐ ☐ ☐ | ☐ ☐ ☐ ☐ | | ☐ | ST | ☐ | ☐ | ☐ | ☐ |
| | | | | | | VIS | ☐ | ☐ | ☐ | ☐ |
| | | | | | | OTH | ☐ | ☐ | ☐ | ☐ |

Predominant level of findings and treatment: ☐ Bones ☐ Fascia/Dura ☐ Fluid ☐ CNS ☐ Embryonic axes

Key Dysfunction / Mechanisms:

Evaluation of patient prior to treatment: ☐ First visit ☐ Resolved ☐ improved ☐ Unchanged ☐ Worse

**A**

**3**

| Dx # | Written Dx | Dx # | Somatic Dysfunction | Dx # | Strain /Sprain |
|---|---|---|---|---|---|
| | | | Head | | Head (closed trauma) |
| | | | Neck | | Neck |
| | | | Thorax | | Thorax |
| | | | Ribs | | Ribs |
| | | | Lumbar | | Lumbar |
| | | | Sacrum | | Sacrum |
| | | | Pelvis | | Pelvis |
| | | | Abdomen | | Abdomen |
| | | | Upp. Extremity ☐ L ☐ R | | Upp. Extremity ☐ L ☐ R |
| | | | Low . Extremity ☐ L ☐ R | | Low. Extremity ☐ L ☐ R |

**P**

**4**

(Also Refer to **OMT columns** in tables of Sections 1 and 2 above)

☐ 1 Meds ☐ 2 OMT ☐ 3 Exercise ☐ 4 Nutrition ☐ 5 X-ray ☐ 6 PT ☐ 7 Lab ☐ 8 Consult ☐ 9 Instructions ☐ 10 Other

| Minutes Spent with the Patient | ☐ 10 | ☐ 15 | ☐ 25 | ☐ 40 | ☐ 60 | ☐ >60 | Follow-up | ☐ 1 | ☐ 2 | ☐ 3 | ☐ 4 | ☐ 5 | ☐ 6 | ☐ 7 | ☐ 8 | ☐ 9 | ☐ 10 | ☐ 11 | ☐ 12 | Units: | ☐ D | ☐ W | ☐ M | ☐ Y | ☐ PRN |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|

Signature of transcriber: _____ Signature of examiner: _____