Outpatient Osteopathic SOAP Note Form

Usage Guide

Note: In order to fulfill documentation guideline requirements, additional information may need to be recorded by the attending physician.

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Outpatient Osteopathic SOAP Note Form

Office of:

Patient's Name: _____ **Section I** Sex: Male ☐ Female ☐ For office use only:

Date: _____ Age: _____

Vital Signs: B/P _____ Pulse _____ Respir. _____ Temp. _____ Wt. _____ Ht. _____

S

CC: _____

HPI: _____ **Section II**

ROS/PFSH: _____

Meds: _____

Level:
2 1-3 HPI
3 1-3 HPI, 1 ROS
4 4+ HPI, 2-9 ROS, 1 PFSH
5 4+ HPI, 10+ ROS, 2+ PFSH

O

Section III

Level of GMS
2 • 1-5 elements
3 • 6+ elements
4 • 2+ from each of 6 areas (or) 12+ elements in 2+ areas
5 • 2+ elements from each of 9 areas

Methods Used to Examine T ☐ A ☐ R – passive ☐ active ☐ T ☐

Severity Scale: 0 No SD or background (BG) levels 1 More than BG levels, minor TART 2 Obvious TART (esp. R and T), +/- symptoms 3 Key lesions, symptomatic, R and T stands out

Section IV

Region Evaluated	Severity 0	1	2	3	Somatic Dysfunctions and Other Systems (MS / SNS / PNS / LYM. / CV / RESP. / GI / FAS. / etc.)	OMT Yes	No	Treatment Method (Circle Treatment Methods Used)	Response R	I	U	W
Head	☐	☐	☐	☐		☐	☐	ART / BLT / CR / CS / DIR / FPR / HVLA IND / INR / LAS / ME / MFR / ST / VIS	☐	☐	☐	☐
Cervical	☐	☐	☐	☐		☐	☐	ART / BLT / CR / CS / DIR / FPR / HVLA IND / INR / LAS / ME / MFR / ST / VIS	☐	☐	☐	☐
Thoracic T1-4	☐	☐	☐	☐		☐	☐	ART / BLT / CR / CS / DIR / FPR / HVLA IND / INR / LAS / ME / MFR / ST / VIS	☐	☐	☐	☐
T5-9	☐	☐	☐	☐		☐	☐	ART / BLT / CR / CS / DIR / FPR / HVLA IND / INR / LAS / ME / MFR / ST / VIS	☐	☐	☐	☐
T10-12	☐	☐	☐	☐		☐	☐	ART / BLT / CR / CS / DIR / FPR / HVLA IND / INR / LAS / ME / MFR / ST / VIS	☐	☐	☐	☐
Lumbar	☐	☐	☐	☐		☐	☐	ART / BLT / CR / CS / DIR / FPR / HVLA IND / INR / LAS / ME / MFR / ST / VIS	☐	☐	☐	☐
Sacrum/Pelvis	☐	☐	☐	☐		☐	☐	ART / BLT / CR / CS / DIR / FPR / HVLA IND / INR / LAS / ME / MFR / ST / VIS	☐	☐	☐	☐
Pelvis/Innom.	☐	☐	☐	☐		☐	☐	ART / BLT / CR / CS / DIR / FPR / HVLA IND / INR / LAS / ME / MFR / ST / VIS	☐	☐	☐	☐
Extremity lower R	☐	☐	☐	☐		☐	☐	ART / BLT / CR / CS / DIR / FPR / HVLA IND / INR / LAS / ME / MFR / ST / VIS	☐	☐	☐	☐
Extremity lower L	☐	☐	☐	☐		☐	☐	ART / BLT / CR / CS / DIR / FPR / HVLA IND / INR / LAS / ME / MFR / ST / VIS	☐	☐	☐	☐
Extremity upper R	☐	☐	☐	☐		☐	☐	ART / BLT / CR / CS / DIR / FPR / HVLA IND / INR / LAS / ME / MFR / ST / VIS	☐	☐	☐	☐
Extremity upper L	☐	☐	☐	☐		☐	☐	ART / BLT / CR / CS / DIR / FPR / HVLA IND / INR / LAS / ME / MFR / ST / VIS	☐	☐	☐	☐
Ribs	☐	☐	☐	☐		☐	☐	ART / BLT / CR / CS / DIR / FPR / HVLA IND / INR / LAS / ME / MFR / ST / VIS	☐	☐	☐	☐
Abd./Other	☐	☐	☐	☐		☐	☐	ART / BLT / CR / CS / DIR / FPR / HVLA IND / INR / LAS / ME / MFR / ST / VIS	☐	☐	☐	☐

Physician's evaluation of patient prior to treatment: First Visit ☐ Resolved ☐ Improved ☐ Unchanged ☐ Worse ☐

A

1. _____ **Section V**

2. _____

P

OMT performed as above: 1-2 areas ☐ 3-4 areas ☐ 5-6 areas ☐ 7-8 areas ☐ 9-10 areas ☐

Meds: _____ PT: _____

Section VI

Exercise: _____

Nutrition: _____

Medical Decisions:
2 Minimal decisions
3 Limited decisions
4 Moderate decisions
5 Excessive decisions (based on # of options, compexity of records, risk of significant complications.)

Minutes spent with patient: ☐ 10 ☐ 15 ☐ 25 ☐ 40 ☐ 60 ☐ >60

Follow-up: ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 8 ☐ 11 ☐ 12 Units: ☐ Days ☐ Wk. ☐ Mo. ☐ Yr. ☐ PRN

Signature of the examiner: _____

Funded under a grant from the AOA Bureau of Research

Outpatient Osteopathic SOAP Note Form

Usage Guide

Introduction:

The following Outpatient Osteopathic SOAP Note Form was developed and tested by the American Academy of Osteopathy's Louisa Burns Osteopathic Research Committee under a grant from the American Osteopathic Association. This valid, standardized and easy to use form is our best recommendation to the Osteopathic Profession for research and training in osteopathic medicine.

Instructions for use:

Print where stated. All printing or writing must be legible to anyone, otherwise the record is useless. Blacken the appropriate rectangles. All boxed areas are critical to research data and should be filled in. Data will be collected and analyzed by a computer. Additions to the form can be made. If data was not obtained for a certain section, leave it blank. All definitions were obtained from the CPT book and the Glossary of Osteopathic Terminology. The headings are presented and arranged as they appear on the form, beginning with the upper left-handed corner and reading to the right and down.

Section I: Headings and Identifications

Patient's Name: Write in the patient's first and last name.

Date: Write in the date of the patient's visit.

Sex: Fill in the box after Male or Female with regards to the patient's gender.

Age: Write in the patient's age in years.

The boxes marked "Office of:" and "For office use only:" can be used for research studies, office record keeping or anyway you'd like.

Vital Signs: Write in the corresponding vital signs on the lines provided labeled B/P (blood pressure), Pulse, Respir. (respirations), Temp (temperature), Wt (weight) and Ht (height). An R (regular) or an I (irregular) can be placed after the number for pulse if known. If a measurement was not taken, leave the space blank.

Section II: Subjective

S: for the **SUBJECTIVE** part of the **S**OAP note.

CC: Stands for **CHIEF COMPLAINT** which is a concise statement describing the symptom, problem, condition, diagnosis or other factor that is the reason for the encounter, usually stated in the patient's words.

HPI: Stands for **HISTORY OF PRESENT ILLNESS** which 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 location, quality, severity, timing, context, modifying factors, and associated signs and symptoms significantly related to the presenting problem(s).

ROS: Stands for **REVIEW OF SYSTEMS** which is an inventory of body systems obtained through a series of questions seeking to identify signs and/or symptoms which the patient may be experiencing or has experienced which are pertinent to the chief complaint. For the purposes of CPT the following elements of a system review have been identified: Constitutional symptoms, Eyes, Ears/Nose/Mouth/Throat, Cardiovascular, Respiratory, Gastrointestinal, Genitourinary, Musculoskeletal, Integumentary, Neurological, Psychiatric, Endocrine, Hematologic/Lymphatic, Allergic/Immunologic. 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.

PFSH: Stands for **PAST, FAMILY, SOCIAL HISTORY.** The **PAST HISTORY** is a review

of the patient's past experiences with illnesses, injuries, and treatments that includes significant information about: prior major illnesses and injuries; prior operations; prior hospitalizations; allergies; age appropriate immunization status and age appropriate feeding/dietary status. The **FAMILY HISTORY** 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 Compliant or History of the Present Illness, and/or System Review; diseases of family members which may be hereditary or place the patient at risk. The **SOCIAL HISTORY** is an age appropriate review of past and current activities that includes significant information about: marital status and/or living arrangements; current employment; occupational history; use of drugs, alcohol, and tobacco; level of education; sexual history; other relevant social factors.

MEDS: Write in the current **MEDICATIONS,** dosage, route and frequency of administration.

LEVEL: This is a guide for criteria needed to be used to justify your evaluation and management CPT code in the subjective section. Circle the level that applies.

2 1-3HPI: This stands for a level two visit requiring one to three History of Present Illnesses. This is also known as ***Problem Focused.***

3 1-3HPI, 1ROS: This stands for a level three visit requiring one to three History of Present Illnesses and one Review of System. This is also known as ***Expanded Problem Focused.***

4 4+HPI,2-9ROS, 1PFSH: This stands for a level four visit requiring four or more History of Present Illnesses, two to nine Review of Systems and one component of Past, Family or Social History. This is also known as ***Detailed.***

5 4+HPI, 10+ROS, 2+PFSH: This stands for a level five visit requiring four or more History of Present Illnesses, ten or more Review of Systems and two or more of Past, Family or Social History. This is also known as ***Comprehensive.***

Section III: Objective

O: for the **OBJECTIVE** section of the S**O**AP note. Put your physical exam findings for areas/systems in this section. Gait and station as well as inspection and/or palpation of digits and nails for the GMS musculoskeletal exam can be put into this section to fulfill all elements of the exam that aren't included in the somatic dysfunction table. Overflow data from the musculoskeletal exam can also be put here.

LEVEL GMS: This is a guide for criteria needed to be used to justify your evaluation and management CPT code in the objective section for the **GENERAL MULTI-SYSTEM EXAMINATION (GMS).** The following body parts and organ systems are recognized: Constitutional, Eyes, Ears/Nose/Mouth/Throat, Neck, Respiratory, Cardiovascular, Chest(Breasts), Gastrointestinal(Abdomen), Genitourinary, Lymphatic, Musculoskeletal, Skin, Neurologic, Psychiatric. See the CPT book for definitions of elements and bullets. Circle the level that applies.

2 1-5 Bulleted elements: For a level two visit you must have examined one to five elements identified by a bullet. This is also known as ***Problem Focused.***

3 6+ Bulleted elements: For a level three visit you must have examined at least six elements identified by a bullet. This is also known as ***Expanded Problem Focused.***

4 2+ Bulleted elements from each of 6 areas OR 12+ elements in 2+ areas: For a level four visit you must have done an examination of at least two elements identified by a bullet from each of six areas/systems **OR** at least twelve elements identified by a bullet in two or more areas/systems. This is also known as ***Detailed.***

5 2+ Bulleted elements from each of 9 areas: For a level five visit you must perform all elements identified by a bullet in at least nine organ systems or body areas and document at least two elements identified by a bullet from each of nine areas/systems. This is also known as ***Comprehensive.***

Be advised for the musculoskeletal section of the **General Multi-system Exam** the six areas are: 1) head and neck; 2) spine, ribs and pelvis; 3) right upper extremity; 4) left upper extremity; 5) right lower extremity; 6) left lower extremity.

Warning: To fulfill the elements for anyone of the above areas, in addition to indicating **TART** findings you must also include an examination of **gait and station** and **inspection and/or palpation of digits and nails.**

Section IV: Musculoskeletal Table

METHODS USED TO EXAMINE: Be sure to blacken in the rectangles indicating the tools you used for your examination (T, A, R, T). Included in the definition of these components is the criteria required for coding in each body area.

- **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 rectangles is a shortcut to a full narrative documentation in the Somatic Dysfunction section.

REGION EVALUATED: This is a list of musculoskeletal body regions arranged in order based on the ICD-9 diagnoses. They include: Head; Cervical; Thoracic; Lumbar; Sacral; Pelvis; Lower Extremities; Upper Extremities; Rib Cage; Abdomen and other (viscera falls into this category). The thoracic region is broken down into three parts based on vertebral levels for specificity: T1-4, T5-9 and T10-12. This was done for ease in listing interrelationships between systems.

SEVERITY: This section refers to the severity **(None (0), mild (1), moderate (2), severe (3))** of the most effected somatic dysfunction in a region. Fill in one box for each region examined. For regions that are not examined leave the box empty. 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 elements, may or may not be overtly symptomatic but significant R and/or T.
- **3 Severe**.....**KEY LESIONS,** significant symptomatic, stands out; R and/or T elements stand out with minimum search or provocation.

(In the center of the table is a quick reference for the severity scale.)

SOMATIC DYSFUNCTION & OTHER SYSTEMS: 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. In this section for each region assessed, write your somatic dysfunctions including musculoskeletal (MS); sympathetic nervous system (SNS); parasympathetic nervous system (PSNS); lymphatic (LYM); cardiovascular (CV); respiratory (RESP); gastrointestinal (GI); fascial (FAS); etc. components. Use standard terminology. **If you filled in boxes under TART you do not need to write anything here for coding purposes but it is a good section to put in your notes for personal use.**

OMT: If boxes 0, 1, 2, or 3 are filled in under severity then there **must** be a mark in the OMT section for that same region. Fill in the YES box if Osteopathic Manipulative Treatment (OMT) was performed or the No box if no OMT was performed for each region examined.

TREATMENT METHOD: Listed here are the abbreviations approved by the profession for the treatment modalities used to treat the somatic dysfunctions listed previously. Circle the modalities used in each region treated.

- **ART:** articulatory treatment
- **BLT:** balanced ligamentous tension treatment/ ligamentous articular strain treatment

CR: cranial treatment/osteopathy in the cranial field/cranial osteopathy
CS: counterstrain treatment
DIR: direct treatment
FPR: facilitated positional release treatment
HVLA: high velocity/low amplitude treatment
IND: indirect treatment
INR: integrated neuromuscular release
LAS: ligamentous articular strain treatment/balanced ligamentous tension treatment
ME: muscle energy treatment
MFR: myofascial release treatment
ST: soft tissue treatment
VIS: visceral manipulative treatment

RESPONSE: Fill in one box for each region of somatic dysfunction that was treated with OMT. This is the physicians perception of how the somatic dysfunctions in each region responded to Osteopathic Treatment immediately after treatment. The boxes are indicated as follows:

R: The somatic dysfunction is completely ***RESOLVED*** without evidence of it having ever 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 after treatment.

PHYSICIAN'S EVALUATION OF PATIENT PRIOR TO TREATMENT: This is the physician's overall opinion of how well the patient is doing based on his or her objective findings of the patient prior to treatment compared to the last visit.

FIRST VISIT: If this is the patients first visit for a particular problem, mark the rectangle after first visit.
RESOLVED: The problems for which the patient is following up on are resolved. This implies that if a patient presents for a follow up on a musculoskeletal problem, there are no findings in the table under the somatic dysfunction section. However, the region assessed could be checked with zero severity indicating that no somatic dysfunction was found.
IMPROVED: The problems for which the patient is following up on are improved but not totally resolved.
UNCHANGED: The problems for which the patient is following up on are no different or completely unchanged from the way they were at the prior visit. This implies that for musculoskeletal problems the general severity of the overall somatic findings in a patient are similar to what they were at the last visit even if they are not exactly the same. This may also happen if you evaluate or consult on a patient at one visit but do not institute any treatment at that visit.
WORSE: The problems for which the patient is following up on are worse then they were at the last visit. This could occur with a musculoskeletal problem if no treatment was started at the last visit, the patient did something to aggravate their condition or the patient had a complication or side effect of treatment given at the last visit. This refers to how the patient is at the current visit. This does not reflect how their early delayed response, i.e. "flare up", from the last treatment was. Flare up information can be charted in the subjective section of the note.

Section V: Assessment

A: for the **ASSESSED** section of the SO**A**P note.

1-4 spaces are available fro ICD-9 diagnoses to be listed in the order of their importance.

Section VI: Plan

P: for the **Plan** Section of the SOA**P** form.

OMT PERFORMED AS ABOVE: Fill in the box for the number of regions of somatic dysfunction that were treated. This number should correlate with the number of YES boxes in the OMT section of the table and the number of boxes in the severity section of the table marked one, two, or three. Beware that although the Thoracic region is divided into three sections on the table it only counts as **one** region for CPT coding. The boxes are as follows:

1-2 areas: You treated one to two regions of somatic dysfunction with Osteopathic Manipulative Treatment.

3-4 areas: You treated three to four regions of somatic dysfunction with Osteopathic Manipulative Treatment.

5-6 areas: You treated five to six regions of somatic dysfunction with Osteopathic Manipulative Treatment.

7-8 areas: You treated seven to eight regions of somatic dysfunction with Osteopathic Manipulative Treatment.

9-10 areas: You treated nine to ten regions of somatic dysfunction with Osteopathic Manipulative Treatment.

MEDS: List in this space any medications the patient will continue on or new medication that will be started.

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 handouts.

NUTRITION: List in this space any nutritional, food or diet recommendations that you have given or will give your patient.

PT: List in this space any Physical Therapy modalities your patient currently does, has received in the office or you recommend they receive.

OTHER: List in this space anything that doesn't fit into any of the other categories. For example, counseling could be addressed in this section. If 50% or more of your time spent with the patient was spent in counseling or educating the patient, specifically list what topics were discussed, what details were included, what handouts or educational material were given and what referrals were made. Then choose your CPT code based on time spent. Examples: 99212 for 10 minutes, 99213 for 15 minutes, 99214 for 25 minutes and 99215 for 40 minutes spent. If longer than 40 minutes was spent in counseling look at the prolonged service codes.

MEDICAL DECISIONS: This is a guide for criteria needed to be used to justify your evaluation and management CPT code in the Plan section. It is based on the number of options, complexity of records and risk of significant complications. Circle the level that applies.

2 **Minimal Decisions:** This stands for a level two visit requiring ***minimal decision making***.

3 **Limited Decisions:** This stands for a level three visit requiring ***limited decision making***.

4 **Moderate Decisions:** This stands for a level four visit requiring ***moderate decision making***.

5 **Extensive Decisions:** This stands for a level five visit requiring ***extensive decision making***.

MINUTES SPENT WITH PATIENT: Fill in the box 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 or >60 minutes. These correspond to the time allotments in the CPT book. Choose the one that best fits.

FOLLOW-UP AND UNITS: Fill in the boxes that corresponds to when you would like to see the patient again both in number and units. For example for one month fill in the box above 1 and the box above Mo.(month). Other abbreviations are as follows: Days, Wk.(week), Yr.(year) and PRN(as needed).

SIGNATURE of the examiner: Write your signature in this space.

Outpatient Osteopathic SOAP Note Form

Office of:

Patient's Name: Jane Doe Sex: Male ☐ Female ■ For office use only:

Date: 1/1/98 Age: 25

Vital Signs: B/P 120/80 Pulse 80 Respir. 20 Temp. 98° Wt. 130 Ht. 5' 5"

S

CC: stomachache, back pain ⊕ flonex 1d p OMT

HPI: started 2 days ago, hurts mostly mid epigast. & mid back, ⊗ radiation, eating & bed rest help

ROS / PFSH: ⊗ N/V/D ⊗ trauma, Dad deceased 46 yo of PUD

Meds: Nu-flex 500 mg BID

Level:
2 1-3 HPI
3 1-3 HPI, 1 ROS
4 4+ HPI, 2-9 ROS, 1 PFSH
5 4+ HPI, 10+ ROS, 2+ PFSH

O

Abd - tender epigastrium, ⊕ bowel sounds, ⊗ masses.
UE blat. muscle strength 5/5

Level of GMS
2 • 1-5 elements
3 • 6+ elements
4 • 2+ from each of 6 areas (or) 12+ elements in 2+ areas
5 • 2+ elements from each of 9 areas

Methods Used to Examine: T ■ A ■ R – passive / active ■ T ■

Severity Scale: 0 No SD or background (BG) levels 2 Obvious TART (esp. R and T), +/- symptoms 1 More than BG levels, minor TART 3 Key lesions, symptomatic, R and T stands out

Region Evaluated	Severity 0	1	2	3	Somatic Dysfunctions and Other Systems (MS / SNS / PNS / LYM. / CV / RESP. / GI / FAS. / etc.)	OMT Yes	No	Treatment Method (Circle Treatment Methods Used)	Response R	I	U	W
Head	☐	■	☐	☐	parietal area tender to touch	■	☐	ART / BLT / CR / CS / DIR / FPR / HVLA IND / INR / LAS / ME / MFR / ST / VIS	■	☐	☐	☐
Neck	☐	☐	■	☐		■	☐	ART / BLT / CR / CS / DIR / FPR / HVLA IND / INR / LAS / ME / MFR / ST / VIS	☐	■	☐	☐
Thoracic T1-4	☐	☐	☐	■	T3L T5R 1	■	☐	ART / BLT / CR / CS / DIR / FPR / HVLA IND / INR / LAS / ME / MFR / ST / VIS	☐	☐	■	☐
T5-9	☐	☐	☐	■	T5R T7L (GI)	■	☐	ART / BLT / CR / CS / DIR / FPR / HVLA IND / INR / LAS / ME / MFR / ST / VIS	☐	☐	■	☐
T10-12	☐	☐	■	☐	T10FSR R	■	☐	ART / BLT / CR / CS / DIR / FPR / HVLA IND / INR / LAS / ME / MFR / ST / VIS	■	☐	☐	☐
Lumbar	☐	☐	■	☐	myofascial strain	■	☐	ART / BLT / CR / CS / DIR / FPR / HVLA IND / INR / LAS / ME / MFR / ST / VIS	■	☐	☐	☐
Pelvis/Sacrum	■	☐	☐	☐	WNL	☐	■	ART / BLT / CR / CS / DIR / FPR / HVLA IND / INR / LAS / ME / MFR / ST / VIS	☐	☐	☐	☐
Pelvis/Innom.	☐	☐	☐	☐		☐	☐	ART / BLT / CR / CS / DIR / FPR / HVLA IND / INR / LAS / ME / MFR / ST / VIS	☐	☐	☐	☐
Extremity lower R	☐	■	☐	☐	Abductor tender TFL	☐	■	ART / BLT / CR / CS / DIR / FPR / HVLA IND / INR / LAS / ME / MFR / ST / VIS	■	☐	☐	☐
Extremity lower L	☐	☐	☐	☐		☐	☐	ART / BLT / CR / CS / DIR / FPR / HVLA IND / INR / LAS / ME / MFR / ST / VIS	☐	☐	☐	☐
Extremity upper R	☐	☐	☐	☐		☐	☐	ART / BLT / CR / CS / DIR / FPR / HVLA IND / INR / LAS / ME / MFR / ST / VIS	☐	☐	☐	☐
Extremity upper L	☐	☐	■	☐	Abduction 160°	■	☐	ART / BLT / CR / CS / DIR / FPR / HVLA IND / INR / LAS / ME / MFR / ST / VIS	☐	■	☐	☐
Ribs	☐	☐	☐	☐		☐	☐	ART / BLT / CR / CS / DIR / FPR / HVLA IND / INR / LAS / ME / MFR / ST / VIS	☐	☐	☐	☐
Other/Abd.	☐	☐	☐	■	↓ mobility stomach greater curvature	■	☐	ART / BLT / CR / CS / DIR / FPR / HVLA IND / INR / LAS / ME / MFR / ST / VIS	☐	☐	☐	■

Physician's evaluation of patient prior to treatment: First Visit ☐ Resolved ☐ Improved ☐ Unchanged ■ Worse ☐

A

1. Gastritis
2. Thoracic strain
3. SDT/A/LE/UE/C/H/L
4.

P

OMT performed as above: 1-2 areas ☐ 3-4 areas ☐ 5-6 areas ☐ 7-8 areas ■ 9-10 areas ☐

Meds: Add Prilosec 20mg po qd

PT: Hot Packs done
Heat at home to Thoracic area

Exercise: shoulder stretches given

Other: Emotional Support given for 5 minutes

Nutrition: Bland diet

Medical Decisions:
2 Minimal decisions
3 Limited decisions
4 Moderate decisions
5 Excessive decisions: (based on # of options, complexity of records, risk of significant complications.)

Minutes spent with patient: ☐ 10 ☐ 15 ■ 25 ☐ 40 ☐ 60 ☐ >60

Follow-up: ■ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 8 ☐ 11 ☐ 12 Units: ☐ Days ■ Wk. ☐ Mo. ☐ Yr. ☐ PRN

Signature of the examiner: [signature] DO

Funded under a grant from the AOA Bureau of Research

Outpatient Osteopathic SOAP Note Form

Office of:

Patient's Name: _____ Sex: Male ☐ Female ☐ For office use only:

Date: _____ Age: _____

Vital Signs: B/P _____ Pulse _____ Respir. _____ Temp. _____ Wt. _____ Ht. _____

S

CC: _____

HPI: _____

Level:
2 1-3 HPI
3 1-3 HPI, 1 ROS
4 4+ HPI, 2-9 ROS, 1 PFSH
5 4+ HPI, 10+ ROS, 2+ PFSH

ROS/PFSH: _____

Meds: _____

O

Level of GMS
2 • 1-5 elements
3 • 6+ elements
4 • 2+ from each of 6 areas
(or) 12+ elements in 2+ areas
5 • 2+ elements from each of 9 areas

Methods Used to Examine T ☐ A ☐ R – passive ☐ active ☐ T ☐

Severity Scale: 0 No SD or background (BG) levels 2 Obvious TART (esp. R and T), +/- symptoms 1 More than BG levels, minor TART 3 Key lesions, symptomatic, R and T stands out

Region Evaluated	Severity 0	1	2	3	Somatic Dysfunctions and Other Systems (MS / SNS / PNS / LYM. / CV / RESP. / GI / FAS. / etc.)	OMT Yes	No	Treatment Method (Circle Treatment Methods Used)	Response R	I	U	W
Head	☐	☐	☐	☐		☐	☐	ART / BLT / CR / CS / DIR / FPR / HVLA IND / INR / LAS / ME / MFR / ST / VIS	☐	☐	☐	☐
Cervical	☐	☐	☐	☐		☐	☐	ART / BLT / CR / CS / DIR / FPR / HVLA IND / INR / LAS / ME / MFR / ST / VIS	☐	☐	☐	☐
Thoracic T1-4	☐	☐	☐	☐		☐	☐	ART / BLT / CR / CS / DIR / FPR / HVLA IND / INR / LAS / ME / MFR / ST / VIS	☐	☐	☐	☐
T5-9	☐	☐	☐	☐		☐	☐	ART / BLT / CR / CS / DIR / FPR / HVLA IND / INR / LAS / ME / MFR / ST / VIS	☐	☐	☐	☐
T10-12	☐	☐	☐	☐		☐	☐	ART / BLT / CR / CS / DIR / FPR / HVLA IND / INR / LAS / ME / MFR / ST / VIS	☐	☐	☐	☐
Lumbar	☐	☐	☐	☐		☐	☐	ART / BLT / CR / CS / DIR / FPR / HVLA IND / INR / LAS / ME / MFR / ST / VIS	☐	☐	☐	☐
Sacrum/Pelvis	☐	☐	☐	☐		☐	☐	ART / BLT / CR / CS / DIR / FPR / HVLA IND / INR / LAS / ME / MFR / ST / VIS	☐	☐	☐	☐
Pelvis/Innom.	☐	☐	☐	☐		☐	☐	ART / BLT / CR / CS / DIR / FPR / HVLA IND / INR / LAS / ME / MFR / ST / VIS	☐	☐	☐	☐
Extremity lower R	☐	☐	☐	☐		☐	☐	ART / BLT / CR / CS / DIR / FPR / HVLA IND / INR / LAS / ME / MFR / ST / VIS	☐	☐	☐	☐
Extremity lower L	☐	☐	☐	☐		☐	☐	ART / BLT / CR / CS / DIR / FPR / HVLA IND / INR / LAS / ME / MFR / ST / VIS	☐	☐	☐	☐
Extremity upper R	☐	☐	☐	☐		☐	☐	ART / BLT / CR / CS / DIR / FPR / HVLA IND / INR / LAS / ME / MFR / ST / VIS	☐	☐	☐	☐
Extremity upper L	☐	☐	☐	☐		☐	☐	ART / BLT / CR / CS / DIR / FPR / HVLA IND / INR / LAS / ME / MFR / ST / VIS	☐	☐	☐	☐
Ribs	☐	☐	☐	☐		☐	☐	ART / BLT / CR / CS / DIR / FPR / HVLA IND / INR / LAS / ME / MFR / ST / VIS	☐	☐	☐	☐
Abd./Other	☐	☐	☐	☐		☐	☐	ART / BLT / CR / CS / DIR / FPR / HVLA IND / INR / LAS / ME / MFR / ST / VIS	☐	☐	☐	☐

Physician's evaluation of patient prior to treatment: First Visit ☐ Resolved ☐ Improved ☐ Unchanged ☐ Worse ☐

A

1. _____ 3. _____

2. _____ 4. _____

P

OMT performed as above: 1-2 areas ☐ 3-4 areas ☐ 5-6 areas ☐ 7-8 areas ☐ 9-10 areas ☐

Meds: _____ PT: _____

Exercise: _____ Other: _____

Nutrition: _____

Medical Decisions:
2 Minimal decisions
3 Limited decisions
4 Moderate decisions
5 Excessive decisions (based on # of options, compexity of records, risk of significant complications.)

Minutes spent with patient: ☐ 10 ☐ 15 ☐ 25 ☐ 40 ☐ 60 ☐ >60

Follow-up: ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 8 ☐ 11 ☐ 12

Units: ☐ Days ☐ Wk. ☐ Mo. ☐ Yr. ☐ PRN

Signature of the examiner: _____

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