

PENNSYLVANIA MYOTHERAPY INSTITUTE

S.O.A.P. NOTES

Client Name: _____ Date: _____

Duration of appt: _____ Type of session: _____

Current Medications: _____

S (Symptoms: Location/Intensity/Frequency/Onset/Duration; Activities affecting condition or affected by condition; The client's functional goals)

O (Visual, palpable observations; applied modalities; instructions to the client) _____

A (Resulting subjective and objective changes; comments) _____

P (Follow-up plan; self-care homework/recommendations) _____

(Student)Therapist PLEASE PRINT LEGIBLY: _____

(Student)Therapist signature: _____