

OT SOAP NOTES

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S

SUBJECTIVE INFORMATION

What the client/family states or presents as relevant to therapy,
(Think of it as your client's current status, behavior, or answers to
your questions)



O

OBJECTIVE INFORMATION

Specific tasks performed during the treatment session to address
the client's goals (Measurable, quantitative, and observable
actions during the session)



A

ASSESSMENT

How the client did or how they responded during the treatment.
(Think of it as adding validity and interpreting the information
written in the S and O sections.)



P

PLAN

What you intend to do next time to address how the client
responded this time such as next steps, revisiting of steps, etc.
(Think of it as your treatment plan for next time.)

Occupational Therapy Documentation Examples

Timisha Tross



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