Objective section reference sheet

Free template from soapnotes.xyz. Fill it in by hand or type over it.

OBJECTIVE: WHAT TO RECORD

Source of each finding (measured by you, observed by you, from a result, from a record):

Date and time of measurements:

MEASUREMENTS

Vital signs, with units (as your setting uses them):

Height, weight or other body measures, if relevant:

Pain or symptom scale, if you scored it yourself:

OBSERVATIONS

General appearance and behavior:

Visible findings (swelling, colour, wound, posture, movement):

How the patient moved, spoke or engaged during the visit:

EXAMINATION AND TESTS DONE TODAY

Body system or area examined, and what you found:

Special tests or functional tests, with results:

Range of movement or strength, with the method and units:

RESULTS AND SCORES

Lab or imaging results received since last visit (with dates):

Questionnaire or rating scale scores (name of scale and score):

Comparison with last visit (same measure, same method):

MENTAL HEALTH SETTINGS

Appearance, speech, mood as observed, affect, thought process:

Asked about thoughts of self-harm, and the answer:

Scores on rating scales, with the name of the scale:

BEFORE YOU MOVE TO ASSESSMENT

Could someone else repeat each measurement from what you wrote?

Is every line a finding rather than your opinion of it? Move opinions to Assessment.

Is anything the patient told you in here? Move it to Subjective.

Signature and credentials:

Educational template, not medical or legal advice. Follow your employer and regulator rules.