SOAP note writing checklist

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

BEFORE YOU WRITE

Did you read the last note and the current plan?

Do you know why this visit happened (new problem, follow-up, review)?

Do you have your measures to hand (vitals, scores, range of movement, other tests)?

S: SUBJECTIVE

Did you record the main concern in the patient's words?

Did you add onset, duration, severity and what changes it?

Did you record what has changed since the last visit?

Did you note relevant history, medicines and allergies as reported by the patient?

Did you keep your own conclusions out of this section?

O: OBJECTIVE

Did you list measurements with their units?

Did you describe findings you saw, heard or felt, not your interpretation of them?

Did you include test results and scores, with dates?

Did you use the same measures as last time so changes can be compared?

A: ASSESSMENT

Did you state your clinical impression in one or two lines?

Does it follow from the S and O above?

Did you say whether things are better, the same or worse than last time?

Did you list each problem separately if there is more than one?

P: PLAN

Did you record treatment given today and what happens next?

Did you record advice and education, and that the patient understood it?

Did you record referrals, orders and who owns each one?

Did you give a follow-up date or the signs that should bring the patient back sooner?

BEFORE YOU SIGN

Could a colleague covering for you carry on from this note alone?

Are the date, time and your name and credentials on it?

Does it meet your employer's and payer's content rules?

Signature and credentials:

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