

# WHAT ARE SOAP NOTES?

Subjective, Objective, Assessment, Plan

**S**

## SUBJECTIVE

The first step is to gather all the information that the client has to share about their own symptoms. The patient will tell you about their experience with the symptoms and condition, as well as what they perceive to be their needs and goals for treatment.

**O**

## OBJECTIVE

The objective portion of SOAP notes relates to how the body functions and evaluates neurological functioning with the Mental Status Exam. What observations can you make about the individual? Write them down as factually as possible.

**A**

## ASSESSMENT

Both the Subjective and Objective elements previously recorded come into effect in the Assessment phase. You will document your impressions and make interpretations based on the information you've gathered.

**P**

## PLAN

This is where the previous three sections all come together to help you determine the course of future treatment. Your Plan notes should include actionable items for each diagnosis. |

# Writing Soap Notes

**Julia Schneider**



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