SOFTWARE & TECH

Occupational Therapy Soap Note Examples

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Mastering Occupational Therapy SOAP Note Examples: A Guide to Effective Documentation

In the fast-paced world of healthcare, precise and thorough documentation is the backbone of quality patient care. For occupational therapy (OT) practitioners, the ability to craft clear, objective, and clinically relevant notes is not just a regulatory requirement—it is a skill that directly impacts treatment outcomes, reimbursement, and interprofessional communication. Among the most widely used documentation formats is the SOAP note, an acronym for Subjective, Objective, Assessment, and Plan. Mastering this structure ensures that every note tells a complete story of the patient's journey. In this comprehensive guide, we will explore several **occupational therapy SOAP note examples**across different settings, break down each component, and provide actionable tips to elevate your documentation to the next level.

What Exactly Is a SOAP Note in Occupational Therapy?

A SOAP note is a method of documentation used by healthcare professionals to record patient encounters in a structured, logical manner. Each letter represents a distinct section that, together, creates a cohesive clinical picture. For occupational therapists, SOAP notes serve multiple purposes: they track progress toward functional goals, justify the medical necessity of interventions, and facilitate collaboration with physicians, nurses, and other therapists. The **occupational therapy SOAP note examples**you will encounter demonstrate how to weave together subjective reports, objective measurements, clinical reasoning, and forward-looking plans into a single, readable document.

Why Effective Documentation Matters in OT

Documentation goes beyond bureaucracy. High-quality notes reflect the therapist's clinical judgment, highlight the value of occupational therapy, and ensure continuity of care. Inadequate notes can lead to denied insurance claims, miscommunication among the care team, and even legal liability. By studying real-world **occupational therapy SOAP note examples**, practitioners can better understand how to capture the nuance of each session—from a pediatric patient struggling with fine motor skills to an older adult relearning how to dress after a stroke. The goal is always to paint a clear, evidence-based picture of the patient's current status and the next steps in their rehabilitation journey.

Breaking Down the SOAP Note Structure

Let's unpack each section before diving into full examples. Understanding the purpose of each part is essential for creating notes that are both comprehensive and concise.

The subjective section captures what the patient or their caregiver reports. This can include complaints of pain, feelings of frustration, descriptions of how they slept, or any changes in their condition since the last visit. Use

direct quotes when possible, but always maintain confidentiality. For example: “Patient states, ‘I had a hard time buttoning my shirt this morning, and my right hand feels stiff.’” The subjective data sets the stage for the objective findings that follow.

Here, the therapist records factual, measurable information. This includes vital signs, range of motion measurements, strength grades, functional test scores, and descriptions of the patient’s performance during activities. In OT, objective data often involves standardized assessments like the **Functional Independence Measure (FIM)** or the **Canadian Occupational Performance Measure (COPM)**. For instance: “Patient required moderate assistance to don a pullover shirt (modified independent with adaptive equipment).” Avoid subjective language here—stick to what you see, hear, and measure.

The assessment is where the therapist synthesizes the subjective and objective information to form a clinical judgment. This section should include the therapist’s analysis of progress, barriers to improvement, and any changes in the treatment plan. For example: “Patient continues to demonstrate decreased grip strength (right hand 12 lbs, left hand 25 lbs) impacting ability to perform kitchen tasks. However, improved sit-to-stand control noted. Continued focus on strengthening and compensatory strategies is warranted.” The assessment is the heart of the note—it explains the “why” behind the plan.

Finally, the plan outlines the specific interventions, frequency, and goals for the next session or beyond. This section should be actionable and, when possible, tie back to the long-term occupational goals. For example: “Continue OT 3x/week for 4 weeks. Focus on bilateral upper extremity strengthening, self-feeding with adaptive utensils, and caregiver education on transfer safety. Reassess for discharge planning in 2 weeks.”

Comprehensive Occupational Therapy SOAP Note Examples

To truly understand how to write powerful notes, it helps to see them in context. Below are three detailed **occupational therapy SOAP note examples**representing common practice areas: pediatrics, adult physical rehabilitation, and mental health.

Subjective (S): Mother reports, “Liam has been avoiding using crayons at home. He gets frustrated when he can’t draw a circle like his sister.” Liam stated, “I don’t want to color—it hurts my hand.” No new medical concerns reported.

Objective (O): Patient presented to clinic in a cooperative mood. Gross motor skills appear age-appropriate. Fine motor assessment using the **Peabody Developmental Motor Scales (PDMS-2)**indicated a grasping subscale score at the 5th percentile for age (22 months). Right-hand dominant; observed poor tripod grasp with significant thumb adduction during a 3-minute drawing task. Required verbal cues and hand-over-hand assistance to maintain a dynamic grasp on a broken crayon. Maximum attention span of 2 minutes for unstructured play.

Assessment (A): Liam demonstrates significant deficits in fine motor coordination and hand strength, impacting his ability to participate in age-appropriate prewriting activities. The avoidance behavior reported by mother likely stems from frustration and fatigue. During the session, he responded well to positive reinforcement and a structured activity (picking up small beads using tongs). Hand strength has improved 10% since last visit. Continued sensory and motor interventions are indicated to build foundational skills before school entry.

Plan (P): Continue OT 1x/week. Next session: Introduce playdough manipulation for intrinsic hand strengthening, graded scissors for bilateral coordination, and a visual schedule to increase attention. Home program: mother to provide 5 minutes daily of “warm-up” hand exercises (squeezing a stress ball, finger walks). Reassess using PDMS-2 in 6 weeks.

Subjective (S): Patient reported, “I feel like my left arm is getting a little stronger, but I still can’t hold a glass without spilling.” Denied pain but noted fatigue after 20 minutes of therapy. Wife present and stated she is

"worried about him falling when he tries to reach for things on the counter."

Objective (O): Patient is a 72-year-old male, 8 weeks post left CVA with right-sided hemiparesis. Vital signs stable (BP 128/76, HR 72). Right upper extremity: shoulder flexion 0–110 degrees, elbow flexion 0–130 degrees (limited end range). Modified Ashworth Scale: 1+ in biceps. Grip strength (Jamar): right hand 8 lbs (left 35 lbs). Functional assessment: required moderate assistance to set up a table for a puzzle; able to grasp a large-handled cup with supervision but frequently lost grip after 3 repetitions. Self-feeding assessed using the **FIM™ instrument**: Score 4 (minimal assistance). Observed compensatory trunk flexion when reaching forward.

Assessment (A): Patient is making slow but steady gains in right upper extremity range of motion and functional use. The primary limitation remains reduced grip strength and sustained grasp endurance, which directly impacts safety and independence during meals and hygiene tasks. Caregiver anxiety is a notable barrier—wife may be inadvertently limiting opportunities for practice. The session showed improved single-hand task strategy (using non-affected hand to stabilize objects). Current rate of progress indicates a need for continued skilled OT to prevent learned non-use and address environmental safety.

Plan (P): Continue OT 5x/week in skilled nursing facility. Goals: increase grip strength to 12 lbs within 2 weeks, improve FIM self-feeding score to 5 (supervision) by discharge. Next session: introduce graded putty exercises, practice pouring from a small pitcher, and conduct a home safety evaluation. Provide wife with written handout on "supportive supervision vs. doing for the patient." Reassess tolerance for therapy by increasing session length to 35 minutes.

Subjective (S): Patient stated, "I just can't get myself to leave the house to go to the grocery store. I feel like everyone is staring at me." Reported difficulty sleeping and increased irritability. Denied suicidal ideation. Expressed motivation to "get back to normal."

Objective (O): Patient is a 34-year-old female with generalized anxiety disorder referred for OT to address deficits in community mobility and daily routines. Attended session with good hygiene and fair eye contact. Completed the **COPM**: performance score 3.2, satisfaction score 2.8 (scale 1–10). During a graded exposure task (planning a 15-minute walk to a nearby coffee shop), patient exhibited increased heart rate (84 to 112), shallow breathing, and verbal statements "I can't do this." With therapist coaching in diaphragmatic breathing and cognitive reframing, patient completed the planning step but opted not to leave the clinic. Demonstrated ability to create a structured daily schedule (with therapist assistance) for morning self-care and meal prep at home.

Assessment (A): Patient is actively engaged in therapy and demonstrates insight into the link between her anxiety and decreased occupational participation. The graded exposure planning was stopped at the patient's request, respecting autonomy and avoiding overstimulation. She successfully utilized a grounding technique to reduce anxiety from moderate to mild. Her COPM scores indicate significant perceived limitations in community mobility and role satisfaction. Progress is expected with continued use of cognitive behavioral techniques within an occupational frame of reference.

Plan (P): Continue OT 1x/week. Next session: implement a "small step" hierarchy for community outings, starting with walking 50 feet from the clinic entrance. Continue development of morning routine checklist; introduce a mindfulness app. Collaboration with primary therapist to reinforce coping strategies. Re-administer COPM in 4 weeks.

Tips for Writing Outstanding OT SOAP Notes

Now that you have seen concrete **occupational therapy SOAP note examples**, consider these best practices to refine your own documentation:

- Be specific and avoid vague language. Instead of “patient did well,” say “patient completed a 3-step cooking task with 1 verbal cue.”
- Use objective measurements whenever possible. Standardized tests and goniometric readings add credibility.
- Connect the assessment to the plan. Your clinical reasoning should naturally lead to the interventions you choose.
- Keep the focus on occupation. OT notes should emphasize functional performance goals—dressing, cooking, working, playing.
- Write for the reader. Consider that other professionals (physicians, insurers) need to understand the medical necessity of your services.
- Proofread for HIPAA compliance. Never include identifiers like full names or specific dates of birth in training examples; in real notes, follow facility guidelines.

Common Pitfalls to Avoid

Even experienced therapists can slip into unhelpful habits. Watch out for these mistakes when creating **occupational therapy SOAP note examples** in your daily practice:

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