PHYSICAL THERAPY SOAP TEMPLATE

Patient Information		
Name:	DOB:	Referring Provider
Therapist:	Date:	Session #
Subj:		
CC/Diagnosis:		Pain Level: /10
Patient Goals:		Functional Limitations:
Obj:		
Posture/Gait:	ROM:	Strength Testing : ☐ 0 ☐ 1+ ☐ 2+ ☐ 3+ ☐ 4+ ☐ 5+
Balance & Coordination	Functional Activities:	
Special tests:		
Assistive Devices used:		
Assessment:		
Clinical Impression:		
Progress:	Barriers to progress:	
Response to treatment:		
Plan		
Treatment Focus:		
Interventions:	Modalities:	Frequency:
HEP:	Referrals/Follow-up:	
Next Session Goals:		
Signature:	Date:	