PTA SOAP Note with Worked Example

Patient's name: _____ Date of service: _____ dd / mm / yyyy

Date of birth: _____ dd / mm / yyyy Visit number: _____

Referring diagnosis: _____ PTA name and credentials: _____

SCOPE REMINDER

What a PTA documents

A physical therapist assistant documents the treatment delivered and the patient's response to it, within the plan of care the supervising physical therapist established. A PTA does not perform the initial evaluation, write or change the plan of care, or make a discharge decision. Where the patient's status changes, document the finding and notify the supervising PT.

S - SUBJECTIVE

Patient report: pain, function, adherence to home programme, changes since last visit

Pain at rest (0-10): _____ Pain with activity (0-10): _____

Home programme adherence: _____ Days since last visit: _____

O - OBJECTIVE

Exercise / intervention — Parameters, Sets, Reps, Assist

Range of motion — Today / Previous / Goal:

Strength (MMT) — Today / Previous / Goal:

Gait distance — Today / Previous / Goal:

Outcome measure score — Today / Previous / Goal:

Modalities applied: _____ Parameters: _____

Treatment time (minutes): _____ Timed code units: _____

A - ASSESSMENT

State how the patient responded to today's treatment and progress toward the PT's stated goals. Keep to response and progress; the plan of care itself belongs to the supervising physical therapist.

Response to treatment and progress toward goals

P - PLAN

Next visit focus, home programme changes, and communication with the supervising PT

Completed

Completed

- [ ] Supervising PT notified of status change
- [ ] Home programme reviewed with patient
- [ ] Progression within the plan of care
- [ ] Patient education documented
- [ ] Next appointment scheduled
- [ ] PT re-assessment due

Supervising PT: _____ **Date of last PT re-assessment:** _____ dd / mm / yyyy

Next re-assessment due: _____

PTA signature:

WORKED EXAMPLE

Example entry

S — Patient reports right knee pain 3 out of 10 at rest and 5 out of 10 on stairs, improved from 6 out of 10 last visit. Completed the home programme five of seven days. Reports no swelling after the last session.

O — Right knee active range of motion 5 to 118 degrees, up from 5 to 110 degrees on 14 March. Quadriceps MMT 4 out of 5. Supine straight leg raise 3 × 12 without lag. Stationary bike 8 minutes, level 2. Terminal knee extension with red band 3 × 15. Step-ups 15 cm, 3 × 10, with handrail. Ambulated 250 feet without device, no antalgic pattern. Cryotherapy to right knee, 12 minutes, supine, after exercise. Therapeutic exercise 32 minutes.

A — Patient tolerated progression to 15 cm step-ups without pain increase. Range of motion improved 8 degrees since 14 March and is progressing toward the PT goal of 0 to 125 degrees. No adverse response to today's session.

P — Continue per plan of care. Next visit, progress step-up height to 20 cm if pain remains 5 out of 10 or less. Home programme unchanged. Supervising PT notified of range of motion gain; re-assessment due 28 March.

Sources: General-purpose template. Follow your state practice act, your employer's policy, and your payer's documentation requirements.