The term “SOAP notes” refers to a particular format of recording information regarding treatment procedures. Documentation of treatment is an extremely important part of the treatment process. In virtually “all” employment settings, some form of documentation is required and SOAP notes are the most popular format in medical settings. SOAP notes consist of information presented in the following order:

**Subjective:**

This part of your notation should describe your impressions of the client/patient. For example: “David was eager to complete the tasks presented to him today.”

This section should be utilized to report subjective information of clinical significance. The statement “Billy was a cute little boy with blue eyes.” is a subjective statement, however, this observation would probably not be clinically significant with respect to the treatment of this patient.

**Objective:**

This section is where you will report the measurable and observable information that you obtain during the treatment session. For example: “Bob produced words with /s/ in the initial position of words with 80% correct /s/ production in 800/1000 (800 out of 1000 trials).”

Students completing clinical assignments at the Marshall University Speech and Hearing Center are required to include in their objective report the overall measurement (i.e., 90%) as well as the raw data from which the overall was obtained (i.e., 800 out of 1000 trials).

Remember that this section can be used to report behaviors that you observe, not just the behaviors that you are targeting. For example, you could report, “Billy repeatedly attempted to avoid production of /s/ by saying, ‘Let’s do something else.’”

**Assessment:**

This section is where you assess, in descriptive terms, the client’s performance during the session and/or the session itself. For example: “Billy’s performance showed a decrease in accuracy over the last session, however the introduction of new activities required additional explanation which resulted in 500 fewer trials.”

**Plan:**

The final section of your SOAP notes is where you outline the course of treatment, after considering the information you gathered during the session. For example: “Training at the current level will be continued with a modification of activities to provide for physical movement to facilitate sustained motivation and attention.”

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