Outpatient Osteopathic SOAP Note Form Series

Usage Guide

Second Edition
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General Table of Contents

Section Forms 1
Usage Guide 5
Example Forms 14
Blank Forms 18

Complete Table of Contents

Section Forms

Outpatient Health Summary Form 1
Outpatient Osteopathic SOAP Note History Form (Page 1 of 3) 2
Outpatient Osteopathic SOAP Note Exam Form (Page 2 of 3) 3
Outpatient Osteopathic Assessment and Plan Form (Page 3 of 3) 4

Usage Guide

Initial Page: Outpatient Health Summary

Section I: Identification and Disposition

Patient's Name 5
Date 5
Update 5
Date of Birth 5
Sex 5
Phone Numbers 5
Marital Status 5
Significant Others 5
DNR or Resuscitate and Qualifications 5
Religion 5
Next of Kin 5

Section II: Social and Family History

Social History 5
  Employment 5
  Occupation 6
  Education 6
  Tobacco 6
  ETOH 6
  Drugs 6
  Sex Hx 6
Family History 6

Section III: Past Medical History

Past Medical History 6
  CPT # 6
  Start Date of Problem 6
  Problem/Diagnosis 6
Medications 6
  Start Date for Medications 6
  Stop Date for Medications 6
Allergies, Adverse Drug Reactions 6

Section IV: Health Maintenance
- Parameter and Dates 6

Section V: Past Surgical History
- Date and Type 6

Section VI: Consultants
- Consultants 6

"S" Page 1 of 3 Outpatient Osteopathic SOAP Note History Form

Section I: Patient's Name and Date, Patient's Pain Analog Scale and CC
- Patient's Name and Date 7
- Boxes—for Office Use 7
- Patient's Pain Analog Scale 7
- CC (Chief Complaint) 7

Section II: History of Present Illness and Systems and Past History of Medical, Family, and Social History
- History of Present Illness (HPI) 7
  - Level of HPI 7
- Review of Systems (ROS) 7
  - Level of ROS 7
- Past Medical, Family and Social History (PFSH) 8
  - Level of PFSH 8
- Overall History Level 8
- Signature of examiner 8

"O" Page 2 of 3: Outpatient Osteopathic SOAP Note Exam Form

Section I: Patient's Name, Date and Vital Signs
- Patient's Name 8
- Date 8
- Sex 8
- Vital Signs 8
- Boxes—for Office Use 8

Section II: Objective Section (continued as blank lines)

Section III. Horizontal Planes and Level of GMS
- Horizontal Planes 9
- Level of GMS (General Multi-System) 9

Section IV: Musculoskeletal Table
- Method Used to Examine 9
- Region Evaluated 9
- Severity 10
- Somatic Dysfunction and Other Systems 10
- Signature of examiner 10

"A" Page 3 of 3: Outpatient Osteopathic Assessment and Plan Form

Section I: Patient's Name, Date
- Patient's Name 10
- Date 10
- Boxes—for Office Use 10

Section II: Diagnosis and Evaluation Prior to Treatment

Dx No, (diagnosis number) 10
ICD Code 11
Written Diagnosis..... 11
Physician’s Evaluation of Patient Prior to Treatment 11
  First Visit 11
  Resolved 11
  Improved..... 11
  Unchanged 11
  Worse..... 11

"P" Plan of Treatment

Section III: Region, OMT, Treatment Method and Response

Region 11
OMT..... 11
Treatment Method..... 11
Response 12

Section IV: Other Treatment Methods Used

Meds..... 12
Exercise..... 12
Nutrition..... 12
PT..... 12
Other 12

Section V: Coding

Complexity/Assessment/Plan (Scoring)..... 12
  Problems 12
  Risk..... 12
  Data..... 12
Traditional Method—Coding by Components..... 12
Optional Method—Coding by Time 13

Section VI: Minutes Spent With the Patient and Follow-up, OMT Performed (number of areas), Other Procedures Performed and E/M Code

Total Minuets with Patient..... 13
Follow-up and Units..... 13
OMT Performed (number of areas)..... 13
Other Procedures Performed 13
E/M Code 13
Signature of Examiner..... 13

Example Forms

Outpatient Health Summary Form 14
Outpatient Osteopathic SOAP Note History Form (Page 1 of 3)..... 15
Outpatient Osteopathic SOAP Note Exam Form (Page 2 of 3)..... 16
Outpatient Osteopathic Assessment and Plan Form (Page 3 of 3) 17

Blank Forms

Outpatient Health Summary Form 18
Outpatient Osteopathic SOAP Note History Form (Page 1 of 3)..... 19
Outpatient Osteopathic SOAP Note Exam Form (Page 2 of 3)..... 20
Outpatient Osteopathic Assessment and Plan Form (Page 3 of 3) 21

Outpatient Health Summary

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Section I

Patient's Name		**Date**	**Update:**		
Date of Birth	**Sex**	**Phone N**	**Home**		
Marital Status: M S D W			**k**		
Significant Others:		**DNR St** **Resusci**	**Yes**	**No**	**Qualifications:**
Religion:		**Next of Kin:**			

Section II

Social History:	**Employment**	**Occupation**	**Education**	
	Tobacco	**ETOH**	**gs**	**Sex Hx**
Family History:	**M**	**Siblings**	**Others:**	
	F			

Past Medical History

Section III

CPT#	Start Date	Problem / Diagnosis	Medications	Start	Stop

llergies, Adverse Drug Reactions:

Health Maintenance

Section IV

Parameter	Dates							
DPT/DT/TD								
OPV								
MMR								
HIB								
Influenza								
Hepatitis								
PPD/Tine								
Pneumovax								
H & P								
Eye exam								
Dental exam								
PAP smear								
Mammogram								
Urinalysis								
Hemoccult								
Cholesterol								
Sigmoidoscopy								
Others								

Past Surgical History

Section V

Date	Type

Consultants

Section VI

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Outpatient Osteopathic SOAP Note History Form

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Office of:	
For office use only:	

Patient's Name ________________________ **Date**________________ **Age**__________

HISTORY

S (See Outpatient Health Summary Form for details of history)

Patient's Pain Analog Scale: ☐ Not done

NO PAIN WORST POSSIBLE PAIN

Section I

CC

History of Present Illness **Level: HPI**

Elements	☐	**Location**
	☐	**Quality**
	☐	**Severity**
	☐	**Duration**
	☐	**Timing**
	☐	**Context**
	☐	**Modifying factors**
	☐	**Assoc. Signs and Sx**

OR Status of ≥ 3 chronic or inactive conditions

____

____

____

☐	**II** **III**	**1-3 elements reviewed**
☐	**IV** **V**	**≥ 4 elements OR status of ≥ 3 chronic conditions**

Review of Systems (Only ask / record those systems pertinent for this encounter.) ☐ **Not done** **Level: ROS**

☐	**Constitutional (Wt loss, etc.)**
☐	**Eyes**
☐	**Ears, nose, mouth, throat**
☐	**Cardiovascular**
☐	**Respiratory**
☐	**Gastrointestinal**
☐	**Genitourinary**
☐	**Musculoskeletal**
☐	**Integumentary (skin, breast)**
☐	**Neurological**
☐	**Psychiatric**
☐	**Endocrine**
☐	**Hematologic/lymphatic**
☐	**Allergic/immunologic**

Section II

☐	**II**	**None**
☐	**III**	**1 system pertinent to the problem**
☐	**IV**	**2-9 systems**
☐	**V**	**≥ 10 systems**

Past Medical, Family, Social History ☐ Not done **Level: PFSH**

☐	Past history / trauma
	Allergies:
	Medications:
☐	Family history
☐	Social history

☐	**II** **III**	None
☐	**IV**	1 history area
☐	**V**	≥ 2 history areas

Overall History = Average of HPI, ROS or PFSH: ☐ **II** (1-3 HPI) ☐ **III** (1-3 HPI, 1 ROS ☐ **IV** (4+ HPI, 2-9 ROS, 1 PFSH) ☐ **V** (4+ HPI, 10+ ROS, 2+ PFSH)

Signature of transcriber: ______________________

Signature of examiner: ____

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Outpatient Osteopathic SOAP Note Exam Form

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O ☐ Not done

Patient's Name ____________________ **Date** ________ Sex: Male ☐ Female ☐

* Vital Signs (3 of 7) Wt. ____________ Ht. _

Section I

Temp. _________

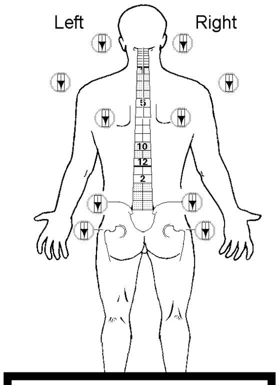
Reg. ☐ Pt. position for r

Resp. __ Pulse ____ Irreg. ☐ Standing________ Sitting________ Lying_________

Office of:

For office use only:

Section II



Section III

Level of GMS

☐	**II**	**1-5 elements**
☐	**III**	**6+ elements**
☐	**IV**	**2+ from each or 6 areas OR 12+ elements in 2+ areas**
☐	**V**	**Perform all elements ≥ 9 areas**

Key to the Severity Scale

0 = No SD or background (BG) levels

1 = More than BG levels, minor TART

2 = Obvious TART (esp. R and T), +/- symptoms

3 = Key lesions, symptomatic, R and T stand out

Section IV

	Methods Used For Examination					**Region Evaluated**	**Severity**				**Somatic Dysfunction and Other Systems**
	All	**T**	**A**	**R**	**T**		**0**	**1**	**2**	**3**	MS / SNS / PNS / LYM. / CV / RESP. / GI / FAS. / etc.
***1**	☐	☐	☐	☐	☐	Head and Face	☐	☐	☐	☐	
	☐	☐	☐	☐	☐	Neck	☐	☐	☐	☐	
***2**	☐	☐	☐	☐	☐	Thoracic T1-4	☐	☐	☐	☐	
	☐	☐	☐	☐	☐	T5-9	☐	☐	☐	☐	
	☐	☐	☐	☐	☐	T10-12	☐	☐			
	☐	☐	☐	☐	☐	Ribs	☐	☐			
	☐	☐	☐	☐	☐	Lumbar	☐	☐	☐	☐	
	☐	☐	☐	☐	☐	Sacrum / Pelvis	☐	☐	☐	☐	
	☐	☐	☐	☐	☐	Pelvis / Innom.	☐	☐	☐	☐	
	☐	☐	☐	☐	☐	Abd ./ Other	☐	☐	☐	☐	
***3**	☐	☐	☐	☐	☐	Upper R	☐	☐	☐	☐	
***4**	☐	☐	☐	☐	☐	Extremity L	☐	☐	☐	☐	
***5**	☐	☐	☐	☐	☐	Lower R	☐	☐	☐	☐	
***6**	☐	☐	☐	☐	☐	Extremity L	☐	☐	☐	☐	

Signature of transcriber: ________________________

Signature of examiner: ____

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Outpatient Osteopathic Assessment and Plan Form

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Section I

A **Patient's Name** ______________________________ ______________

Office of:

For office use only:

Section II

Dx No.	ICD Code	Written Diagnosis	Dx No.	ICD Code	Written Diagnosis
	739.0	Somatic Dysfunction of Head and Fa		739.4	Somatic Dysfunction of Sacrum
	739.1	Somatic Dysfunction of Neck		739.5	Somatic Dysfunction of Pelvis
	739.2	Somatic Dysfunction of Thoracic		739.9	Somatic Dysfunction of Abd / Other
	739.8	Somatic Dysfunction of Ribs		739.7	Somatic Dysfunction of Upper Extremity
	739.3	Somatic Dysfunction of Lumbar		739.6	Somatic Dysfunction of Lower Extremity

Physician's evaluation of patient prior to treatment: First visit ☐ Resolved ☐ Improved ☐ Unchanged ☐ Worse ☐

P

Section III

☐ All not done **Region**	**OMT**		**Treatment Method**															**Response**			
	Y	**N**	ART	BLT	CR	CS	DIR	FPR	HVLA	IND	INR	LAS	ME	MFR	ST	VIS	OTH	**R**	**I**	**U**	**W**
Head and Face	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Neck	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Thoracic T1-4	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
T5-9	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
T10-12	☐	☐	☐	☐	☐	☐	☐				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Ribs	☐	☐	☐	☐	☐	☐	☐				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Lumbar	☐	☐	☐	☐	☐	☐	☐		☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Sacrum	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Pelvis	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Abdomen/Other	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Upper Extremity	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Lower Extremity	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Section IV

Meds: ______________________________

PT: ______________________________

Exercise: ______________________________

r: ______________________________

Nutrition: ______________________________

Complexity / Assessment / Plan (Scoring) *Default to level 2—same criteria

Problems		**Risk** (presenting problem(s), diagnostic procedure(s), management options)	**Data**	**Maximum Points**
Self-limiting	1 (2 max.)		Lab	1
Estimated problem improved / stable	1	Minimal = Min.	Radiology	1
Estimated—worsening.	2	Low	Medicine	1
New—no workup	3 (1 max.)	Moderate = Mod.	Discuss with performing physician	1
New—additional workup	4	High	Obtain records or Hx from others	1
			Review records, discuss with physician	2
			Visualization of tracing, specimen	2

Section V

Level I	Level II	Level III	Level IV	Level V	Level I	Level II	Level III	Level IV	Level V	Level I	Level II	Level III	Level IV	Level V
*	≤1 pt.	2 pt.	3 pt.	≥4 pt.	*	Min.			High	*	≤1 pt.	2 pt.	3 pt.	≥4 pt.
	☐	☐	☐	☐		☐			☐		☐	☐	☐	☐

Requires only 2 above 3 (problems, risk and data). Level of complexity = average of inclu

Traditional Method—Coding by Components					
History	I	II	III	IV	V
Examination	I	II	III	IV	V
Complexity / Assessment Plan	I	II	III	IV	V
Final level of service	☐	☐	☐	☐	☐

All these areas required. Average of three levels of service.

Optional Method—Coding by Time

When majority of the encounter is counseling / coordinating, the level is determined by total time

	I	II	III	IV	V
New patients (minutes)	10	20	30	45	60
Established patients (minutes)		10	15	25	40
Final level of service	☐	☐	☐	☐	☐

Dictate total time and counseling / coordinating time plus a brief description of topics discussed

Minutes spent with the patient: ☐ 10 ☐ 15 ☐ 25 ☐ 40 ☐ 60 ☐ >60

Follow-up: ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐ 11 ☐ 12

Units: ☐ D ☐ W ☐ M ☐ Y ☐ RN

OMT performed as Above: 0 areas ☐ 1-2 areas ☐ ☐ 5-6 areas ☐ 7-8 areas ☐ 9-10 areas ☐

Section VI

Other Procedures	CPT Codes:				
Performed:	Written Dx:				

E/M Code:	**New**	☐	☐	☐	☐	**EST**	☐	☐	☐	☐	☐	**Consults**	☐	☐	☐	☐	☐
Write 992 plus . . .		*02*	*03*	*04*	*05*	. . .	*11*	*12*	*13*	*14*	*15*	. . .	*41*	*42*	*43*	*44*	*45*

Signature of transcriber:

Signature of examiner:

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Outpatient Osteopathic SOAP Note Form Series
Usage Guide

Introduction:

The following Outpatient Osteopathic SOAP Note Form Series was developed by the American Academy of Osteopathy's Louisa Burns Osteopathic Research Committee under a grant from the American Osteopathic Association. This valid, standardized, and easy to use form is our best recommendation to the Osteopathic Profession for research and training in osteopathic medicine.

Instructions for use:

Print where stated. All printing or writing must be legible to anyone, otherwise the record is useless. Blacken the appropriate rectangles. All bold boxed areas are critical to research data and should be filled in. Data can be collected and analyzed by a computer. Additions to the form can be made. If data were not obtained for a certain section, leave it blank or fill in the "not done" rectangle. All definitions were obtained from the CPT book and the Glossary of Osteopathic Terminology. The headings are presented and arranged as they appear on the form, beginning with the upper left-hand corner and reading to the right and down. Bold text in this Usage Guide corresponds to Form text.

Initial Page:
Outpatient Health Summary

This page of the system is the front left hand page of a two-section chart system or the front page of a one-section chart. At each patient visit, it provides rapid ID, recall of wishes for care, who and how to call in case of an emergency, and a quick retrieval of past medical, surgical and medication history, consultants and immunizations. This page is reviewed at each patient visit, and all sections are kept current.

Section I: Identification and Disposition

Patient's Name: Write in the patient's first and last name.

Date: Write in the date this initial summary was started. Use the following format for all dates: month/day/year.

Update: Write in the dates that this form is updated. Separate dates by comma's, with the most recent date furthest to the right (month/day/year).

Date of Birth: (month/day/year).

Sex: **M**ale or **F**emale gender.

Phone Numbers: Provide **Home** phone number and a **Work** phone number, if appropriate.

Marital Status: Circle the correct letter to indicate if **M**arried, **S**ingle, **D**ivorced, or **W**idowed.

Significant Others: List them and include living arrangements.

DNR Status or **Resuscitate? (Yes**, **No)** and **Qualifications:** Indicate the patient's or guardian's wishes regarding resuscitation by checking the "**Yes**" or "**No**" box. Additional desires or wishes for terminal care can be added here in the **Qualifications** box.

Religion: Write in the patient's religion or preference for last rites.

Next of Kin: Write in the name of whom should be contacted in case of emergency, should the patient die, or who is the beneficiary.

Section II: Social and Family History

Social History is an age-appropriate review of past and current activities that includes significant information about:

Employment: Write in the patient's current and past employment, and, if appropriate, places of work. Indicate if patient is retired; indicate any risk factors associated with the work place, i.e., black lung, asbestos exposure, fumes, etc.

Occupation: Write in the patient's areas of training (chemist, teacher, homemaker).

Education: Write in the patient's current school status, degrees obtained, or highest grade obtained.

Tobacco: Write in pack/years, what form (cigarettes, cigars, chewing tobacco), and quit-dates, if appropriate.

ETOH (alcohol): Write in the patient's alcohol use in numbers, what consumed (beer, cocktails), how often (daily, weekly, monthly, yearly). Indicate past abuse and sober date.

Drugs: Write in the patient's illicit drug use, past and present, what, when, and for how long.

Sex Hx (sexual history): Write in the patient's sexual preference, partners, menstrual history, gravida number, and para number. (The female patient has a gravida number if presently pregnant; otherwise she only has a para number. A para number is a 4-digit number indicating the number of "pregnancies-prematures-abortions-and living children.")

Family History is a review of medical events in the patient's family that include significant information about: (**M**other, **F**ather) the health status or cause of death of parents, **Siblings**, and children; specific diseases related to problems identified in the Chief Complaint or History of the Present Illness and/or System Review; diseases of family members which may be hereditary or place the patient at risk.

Use ↑ if the immediate relative (mother, father, sibling, etc.) is living and ↓ if deceased. If deceased, indicate the age of death and cause. List their pertinent health problems or history.

Others: List any pertinent health history or information on other relatives, such as maternal grandmother ↓ age 50, breast cancer, etc.

Section III: Past Medical History

Past Medical History is a review of the patient's past experiences with illness, injuries, and treatment that includes significant information about:

CPT #: Write in any CPT codes that might be helpful for easy reference when coding.

Start Date of Problem: Write in the date when a problem began or when a diagnosis was first made (month/day/year).

Problem / Diagnosis: Write in the patient's prior illnesses, injuries, and prior hospitalizations, in order of occurrence when possible.

Medications: Medications and dosages are listed in order of their initial use. Also list here over-the-counter substances, such as herbs, vitamins, and homeopathic remedies.

Start Date for Medications: Write in the date that each medication/substance was started and when dosages are/were changed (month/day/year).

Stop Date for Medications: Write in the date that each medication/substance was discontinued (month/day/year). Leave blank if the patient currently is taking a medication.

A**llergies, Adverse Drug Reactions:** List medications, foods, animals, etc., that cause allergic reactions or that produced unexpected results. List the nature of the reaction or result.

Section IV: Health Maintenance

Parameter and **Dates:** This is a running list of dates (month/day/year) of the usual immunizations, exams, tests and procedures. There is also a line for "**Others**" write-ins.

Section V: Past Surgical History

Date and **Type:** Surgical dates and types are listed in the order of occurrence (month/day/year).

Section VI: Consultants

Consultants are listed, including the consultant's name and specialty.

Page 1 of 3:
Outpatient Osteopathic SOAP Note History Form
This page of the system provides the subjective portion of a SOAP note for an outpatient patient visit.

S: The Subjective section of the **S**OAP note.

Section I: Patient's Name, Date, Age, Patient's Pain Analog Scale, and CC

Patient's Name, Date, and Age: The first and last name of the patient and the date of this visit are recorded (month/day/year). Write in the patient's age in years. If a child, use days up to 1 month, use months up to 1 year, and years of age.

The boxes marked **Office of:** and **For office use only:** can be used for tracking a research study, for office record keeping, etc.

Patient's Pain Analog Scale: The patient is asked to place a mark on the 0-10 analog scale indicating the degree of pain he/she has at the time of this interview. Patients are given the following instructions: "If you have **NO PAIN**, place a mark at the far left side. If this is the **WORST POSSIBLE PAIN** you have ever experienced, indicate it at the far right side. Indicate where your pain is at this time." If the patient doesn't have pain or this information was not obtained, fill in the "**Not done**" rectangle.

CC Stands for **Chief Complaint**, which is a concise statement describing the symptoms, problem, condition, diagnosis or other factors that is the reason for the encounter. **CC** usually is stated in the patient's words. Extra lines are included here for other details of the subjective history not included in the rest of this section or those needing more space for details.

Section II. History of Present Illness, Review of Systems, and Past Medical, Family and Social History

History of Present Illness (HPI): The HPI is a chronological description of the development of the patient's present illness, from the first sign and/or symptom to the present. This includes a description of location, quality, severity, duration, timing, context, modifying factors, and associated signs and symptoms significantly related to the presenting problem(s). Fill in all rectangles and write in the details after each element listed for the history elicited. OR, write in the status of 3 or more chronic or inactive conditions on the lines provided.

Level: HPI: This is a guide for criteria needed to justify your evaluation and management CPT code in the subjective section. Fill in the rectangle that applies. The Roman numerals stand for the level of the established outpatient visit for which the patient qualifies. A level two (99212) or three (99213) code requires 1-3 of the HPI elements to qualify. A level four (99214) or five (99215) code requires ≥ 4 HPI elements OR the status of ≥ 3 chronic conditions.

Review of Systems (ROS) is an inventory of body systems, pertinent to the chief complaint, that are obtained through a series of questions seeking to identify signs and/or symptoms that the patient may be experiencing or has experienced. ROS is a guide for criteria needed to justify your evaluation and management CPT code in the subjective section. For the purposes of CPT, the following systems review has been identified: Constitutional symptoms, Eyes, Ears/Nose/Mouth/Throat, Cardiovascular, Respiratory, Gastrointestinal, Genitourinary, Musculoskeletal, Integumentary, Neurological, Psychiatric, Endocrine, Hematologic/lymphatic, and Allergic/immunologic. The review of systems helps define the problem, clarify the differential diagnoses, identify needed testing, or serves as baseline data for other systems that might be affected by any possible management options. Only fill in the rectangle(s) of those systems reviewed at this encounter. Write in any details elicited after each system. If you examine a system and it is normal, fill in the rectangle for that system and write Within Normal Limits (WNL) on that line. If no ROS information was obtained, fill in the "**Not done**" rectangle.

Level: ROS: The Roman numerals stand for the level of the established outpatient visit for which the patient qualifies. A level two (99212) requires no ROS. Level three (99213) requires one system pertinent to the problem. Level four (99214) requires 2-9 systems. Level five (99215) requires listing of ≥ 10 systems. Fill in the rectangle that applies.

Past Medical, Family, Social History (PFSH): **Past history / trauma** is a review of the patient's past experiences with illnesses, injuries, and treatments that includes significant information about: prior major illnesses and injuries, prior operations, prior hospitalizations, allergies, age-appropriate immunization status, and age-appropriate feeding/dietary status.

Allergies, including Adverse Drug Reactions: List medications, food, animals, etc., that cause allergic reactions or produce unexpected results. List the reaction or the result.

Medications: Medications and dosages are listed here. Include over-the-counter substances, such as herbs, vitamins, and homeopathic remedies.

Family history is a review of medical events in the patient's family that include significant information about: the health status or cause of death of parents, siblings, and children; specific diseases related to problems identified in the Chief Complaint or History of the Present Illness, and/or Systems Review; diseases of family that may be hereditary or place the patient at risk.

Social history is an age-appropriate review of past and current activities that includes significant information about: marital status and/or living arrangements; current employment; occupational history; use of drugs, alcohol, and tobacco; level of education; sexual history; other relevant social factors.

Fill in the rectangle(s) and write in any extra history not included on the **Outpatient Health Summary Form**, such as trauma history. If no medical, family or social history was obtained on the **Outpatient Health Summary** or the **Outpatient Osteopathic SOAP Note History Form**, fill in the "**Not done**" rectangle.

Level: PFSH: The Roman numerals stand for the level of the established outpatient visit for which the patient qualifies. A level two (99212) and three (99213) requires that no history areas be present. Level four (99214) requires 1 history area. Level five (99215) requires 2 or more history areas. Fill in the rectangle that applies.

Overall History: Fill in the rectangle that indicates the average level determined using the level of HPI, ROS or PFSH provided.

Signature of examiner: Signature of the attending physician is mandatory. Also, the transcriber should sign, if this is appropriate.

Page 2 of 3:
Outpatient Osteopathic SOAP Note Exam Form
This page of the system provides space for recording vital signs and any visceral and musculoskeletal examination findings obtained during your outpatient exam of a patient.

O: The **O**bjective section of the S**O**AP Note.

Section I: Patient's Name, Date, Sex and Vital Signs

Not done: If none of the objective portion was performed, fill in the **Not done** rectangle.

Patient's Name: Write in the patient's first and last name.

Date: Write in the date of the patient's visit (month/day/year).

Sex: Fill in the correct rectangle for **Male** or **Female** gender.

Vital Signs: Write in the corresponding vital signs on the lines provided. Three (3) of the seven (7) listed are needed to fulfill the requirements for a comprehensive examination. The seven include: 1. **Wt.** (weight in pounds, lbs), 2. **Ht.** (height in feet and inches, ft, in), 3. **Temp.** (temperature in degrees Fahrenheit), 4. **Resp.** (rate of respiration in breaths-per-minute), 5. **Pulse** rate (in beats per minute) and whether it is regular (**Reg.**) or irregular (**Irreg.),** 6. **BP** (blood pressure) **Standing**, **Sitting**, and 7. **Lying** down. If a measurement was not taken, leave the space blank.

The boxes marked **Office of:** and **For office use only:** can be used to identify research studies, for office record keeping, etc.

Section II: Objective Section (continued as blank lines).

Physical exam findings for any areas/systems of the **G**eneral **M**ulti-**S**ystem **E**xamination **(GMS)** are recorded in this section. These include: Constitutional, Eyes, Ears/Nose/Mouth/Throat, Neck, Cardiovascular, Respiratory, Chest (Breasts), Gastrointestinal (Abdomen), Genitourinary, Lymphatic, Musculoskeletal, Skin, Neurologic, and Psychiatric. The table that follows provides a section where specific musculoskeletal exam findings can be recorded and documented. Gait and station as well as inspection and/or palpation of digits and nails for the musculoskeletal exam can be put into this section to fulfill all elements of the exam that aren't included in the somatic dysfunction table. Overflow data from the musculoskeletal exam can also be put here. Note: If no physical exam was done at this encounter, fill in the **Not done** rectangle at the top of Section I.

Section III: Horizontal Planes and Level of GMS

Horizontal Planes (Diagram): The diagram can be used to indicate levelness of landmarks, such as mastoid processes, shoulders, inferior angle of the scapula, iliac crests, and the superior border of the greater trochanters. (This same diagram can also be used to denote such things as lateral curvatures, the AP weight bearing line, or any other documentation that may be helpful.)

Level of GMS (General Multi-System): This is a guide for criteria needed to justify your evaluation and management CPT code in the **O**bjective section. See the CPT book for details and definitions of elements. Fill in the rectangle that represents the level that applies.

II	**1-5 elements:** For a level two (99212) visit you must have examined one to five elements identified by a bullet.
III	**6+ elements:** For a level three (99213) visit you must have examined at least six elements identified by a bullet.
IV	**2+ from each of 6 areas OR 12+ elements in 2+ areas:** For a level four (99214) visit you must have done an examination of at least two elements identified by a bullet from each of six areas/systems **OR** at least twelve elements identified by a bullet in two or more areas/systems.
V	**Perform all elements ≥ 9 areas.** For a level five (99215) visit, you must perform all elements identified by a bullet in at least nine organ systems or body areas and document at least two elements identified by a bullet from each of nine areas/systems.

Be advised that for the **Musculoskeletal Exam**, the six areas are: (1) head, face, and neck; (2) spine, ribs, and pelvis; (3) right upper extremity; (4) left upper extremity; (5) right lower extremity; (6) left lower extremity.

Warning: For a comprehensive level of exam, all four of the elements identified in **TART** must be performed and documented for each of four of the six anatomic areas. For the three lower levels of examination, each element is counted separately for each body area. For example, assessing range-of-motion in two extremities constitutes two elements.

Section IV: Musculoskeletal Table

Methods Used for Examination: Be sure to blacken in the rectangles indicating the tools used for your examination (**T**, **A**, **R**, **T**). Included in the definition of these components are the criteria required for coding in each body area.

All:	Indicates that all **TART** criteria were used to examine a region.
T:	**Tissue Texture Change,** stability, laxity, effusions, tone.
A:	**Asymmetry,** misalignment, crepitation, defects, masses.
R:	**Range-of-Motion,** contracture.
T:	**Tenderness,** pain.

Filling in these squares is a shortcut to a full narrative documentation in the **Somatic Dysfunction and Other Systems** section of this table.

Region Evaluated: This is a list of musculoskeletal body regions arranged in order based on the CPT examination documentation requirements. They include: ***1. Head and Face**, and **Neck**; ***2.** The spine (**Thoracic**, **Ribs**, **Lumbar, Sacrum/Pelvis**, **Pelvis/Innom.**, and **Abd./Other**); ***3. Right Upper Extremity**; ***4. Left Upper Extremity**; ***5. Right Lower Extremity**; and ***6. Left Lower Extremity**. The thoracic region is broken down into three parts based on vertebral levels for innervation specificity: **T1-4**, **T5-9**, and **T10-12**. This provides for ease in listing interrelationships between musculoskeletal findings and possible involvement of the visceral system.

Severity: This section refers to the severity [None (**0**), mild (**1**), moderate (**2**), severe (**3**)] of the most affected somatic dysfunction in a region. Fill in one rectangle for each region examined. For regions that are not examined, leave the rectangle empty.

If a rectangle is **not marked** in a region, it is assumed that that region was **not examined**. For regions that are examined, the scale is as follows:

0 None	No somatic dysfunction present or background (BG) level.
1 Mild	More than background, minor **TART** elements.
2 Moderate	Obvious **TART**; in particular **R**ange-of-motion (**R**) and/or **T**issue texture change (**T**) may or may not be overtly symptomatic.
3 Severe	Key lesions observed, significant, symptomatic, stands out; **R** and/or **T** elements stand out with minimum search or provocation.

(At the top of the table is a **Key to the Severity Scale**, which provides for a quick review.)

Somatic Dysfunction & Other Systems: Somatic Dysfunction is defined as impaired or altered function of related components of the somatic (body framework) system: skeletal, arthrodial, and myofascial structure, and related vascular, lymphatic, and neural elements. In this section for each region assessed, write your somatic dysfunctions, including musculoskeletal (MS), sympathetic nervous system (SNS), parasympathetic nervous system (PNS), lymphatic (LYM), cardiovascular (CV), respiratory (RESP), gastrointestinal (GI), fascial (FAS), etc., components. Use standard terminology.

If you filled in rectangles under **TART** you do not need to write anything here for coding purposes; however, this section is useful for recording notes for personal use.

Signature of examiner: Signature of the attending physician is mandatory. Also, the transcriber should sign, if this is appropriate.

Page 3 of 3:

Outpatient Osteopathic Assessment and Plan Form

This page of the system is to be used with the Outpatient Osteopathic SOAP Note History and Exam Forms. It contains the Assessment and Plan for completion of a SOAP note. It provides for the **Written Diagnosis, Physician's evaluation of patient prior to treatment,** treatment **table for OMT,** other instructions and treatments given, coding, instructions, **Minutes spent with the patient**, **Follow-up**, **Units**, **OMT performed**, **Other Procedures Performed**, and **E/M Code**.

A: The Assessment section for the SO**A**P note. This includes patient's name, date, diagnosis and physician's evaluation of patient prior to treatment.

Section I: Patient's Name and **Date**

Patient's Name: Write in the patient's first and last name.

Date: Write in the date of the patient's visit (month/day/year).

The boxes marked **Office of:** and **For office use only:** can be used for tracking a research study, for office record keeping, etc.

Section II: Diagnosis and Evaluation Prior to Treatment:

Dx No. (diagnosis number): Write in your priority numbers in the **Dx No.** column, with "1" being the number of the patient's most severe or addressed diagnosis at this visit.

ICD Code: Write in this column the ICD code that corresponds to your diagnosis, if it has not already been written in.

Written Diagnosis: Write on this line the description for each of your ICD codes, if not already listed.

Physician's Evaluation of Patient Prior to Treatment: This is the physician's overall opinion of how well the patient is doing based on objective findings of the patient prior to treatment as compared to the previous visit(s):

First visit: If this is the patient's first visit for a particular problem, mark the square after **First visit.**

Resolved: If the problem for which a follow-up visit was requested is resolved, mark the square after **R**esolved. Example: If a patient presents for a follow-up on a musculoskeletal problem, filling in the **Resolved** rectangle implies that the region of the previous somatic dysfunction was evaluated, with no abnormal findings being found, and that you also filled in the **0** (zero) rectangle in the severity column for that region in the Musculoskeletal Table (found on page 2 of 3).

Improved: If the problem for which a follow-up visit is improved, but not totally resolved, mark the rectangle after **Improved**.

Unchanged: If the problem for which a follow-up visit was requested is no different or completely unchanged from the prior visit, mark the **Unchanged** rectangle. This implies that, for a musculoskeletal problem, the general severity of the overall somatic findings is similar to that at the last visit. This may also apply if you evaluate or consult on a patient at one visit but do not institute any treatment at that visit.

Worse: If the problem for which a follow-up visit was requested is worse than it was at the last visit, mark the rectangle after **Worse**. This could occur with a musculoskeletal problem if no treatment was started at the prior visit, the patient did something to aggravate their condition, or the patient had a complication or side effect of treatment given at the last visit. This refers to the patient's condition at the current visit. This does not reflect whether the patient had an early delayed response, i.e., a flare-up from the last treatment. Flare-up information can be charted in the **S**ubjective section of these forms (found on page 1 of 3).

Section III: Plan: Region, OMT, Treatment Method and Response

P: The **Plan** Section of the SOA**P** form. This includes a treatment table for Osteopathic Manipulative treatment. Following the table, it also records **Meds** (medications), **Exercise**, **Nutrition**al advice, and **PT** (physical therapy) instructions. **Other** provides space for any additional advice or type of treatment you institute. Also included in this section are areas for coding**, Minutes spent with patient, Follow-Up, OMT performed, Other Procedures Performed,** and **E/M Code**.

Region lists musculoskeletal body regions arranged in order based upon CPT categories. They include **Head and Face**, **Neck**, **Thoracic**, **Ribs**, **Lumbar**, **Sacrum**, **Pelvis**, **Abdomen/Other** (viscera falls into this category), **Upper Extremities**, **Lower Extremities**. If no regions are treated, fill in the **All not done** rectangle.

OMT: Fill in the **Y**es rectangle for each region in which an examination was performed and Osteopathic Manipulative Treatment (OMT) was given. Fill in the **N**o rectangle if OMT was not performed on a region that was examined. Note: For each region treated, there must be rectangles for **Methods Used for Examination** and **Severity** rectangles (1, 2, or 3) filled in for that region of the body examined on the Musculoskeletal Table (found on page 2 of 3).

Treatment Method: Listed here are the abbreviations of manipulative treatment modalities, approved by the profession and included in the Glossary of Osteopathic Terminology, for treatment of the somatic dysfunctions listed previously. Fill in the rectangles that correspond to the modalities used to treat each region.

ART:	articulatory treatment.
BLT:	balanced ligamentous tension / ligamentous articular strain treatment.
CR:	cranial treatment / osteopathy in the cranial field / cranial osteopathy.
CS:	counterstrain treatment.
DIR:	direct treatment.

FPR:	facilitated positional release treatment.
HVLA:	high velocity/low amplitude treatment (thrust treatment).
IND:	indirect treatment.
INR:	integrated neuromuscular release.
LAS:	ligamentous articular strain / balanced ligamentous tension treatment.
ME:	muscle energy treatment.
MFR:	myofascial release treatment.
ST:	soft tissue treatment
VIS:	visceral manipulative treatment.
OTH:	any other OMT treatments used.

Response: Fill in one of these rectangles for each region of somatic dysfunction that was treated with OMT. This is the physician's perception of how the somatic dysfunctions in each region responded to Osteopathic Treatment immediately after treatment. The rectangles are indicated as follows:

R:	The somatic dysfunction is completely **R**esolved without evidence of it ever having been present.
I:	The somatic dysfunction is **I**mproved but not completely resolved.
U:	The somatic dysfunction is **U**nchanged or the same after treatment as it was before treatment.
W:	The somatic dysfunction is **W**orse or aggravated immediately after treatment.

Section IV: Other Treatment Methods Used

Meds: List in this space any medications the patient will continue or new medications that will be started. Risks, benefits, and potential side effects can be listed here.

Exercise: List in this space any exercises you wish the patient to continue or add to their treatment prescription and whether they were discussed, taught, or given as handouts.

Nutrition: List in this space any nutritional, food, or diet recommendations that you have given or will give your patient.

PT: List in this space any Physical Therapy modalities your patient currently receives, has received in the office, or that you recommend they receive or do.

Other: List in this space anything that does not fit into any of the other categories. For example, counseling could be addressed in this section. If 50% or more of your time spent with the patient was spent in counseling or educating the patient, specifically list the topics discussed, the details that were included, the handouts or educational materials given, and what referrals were made.

Section V: Coding

Complexity / Assessment / Plan (Scoring): Only two of the following three categories (**Problems, Risk, Data**) are required for an established visit. Note that there are five levels and five rectangles below the list for each category. Add up the total points earned from each category. Record the total for each category by blackening the appropriate **rectangle** under one of the five levels. The total level for complexity is the average of the three following categories included (Problems, Risk, and Data).

Problems: Find which criteria match this visit. This could be **Self-limited**, **Established problem—improved /stable**, **Established–worsening**, **New—no workup,** or **New—additional workup**. Add points or number of problems that fit this patient in each category. Find the total points under one of the five levels and blacken the appropriate rectangle.

Risk: Find which criteria match this visit. This could be **Minimal**, **Low**, **Moderate**, or **High** based on presenting problems, diagnostic procedures, and management options. Find the level of risk under one of the five levels and blacken the appropriate rectangle. OMT is low risk.

Data: Find which criteria match this visit. This could be **Lab**, **Radiology**, **Medicine**, **Discuss with performing physician**, **Obtain records or Hx from others**, **Review records, discuss with physician**, or **Visualization of tracing**, (or) **specimen**.

Traditional Method—Coding by Components:

For each **History, Examination,** and **Complexity / Assessment / Plan** section, put a circle around the appropriate composite level. All three areas are required for new patient visits. Then blacken the rectangle in the **Final**

Level of Service that denotes the average of the three levels recorded.

Optional Method—Coding by Time:

When the majority of the Encounter (50% or greater) **is counseling /coordinating, the level is determined by total time.** Blacken the rectangle that indicates how much time was spent counseling: **New patients (minutes)**—10, 20, 30, 45, 60; **Established patients (minutes**)—10, 15, 25, 40). Be sure in your plan to write a brief description of topics discussed. (Also be sure to blacken the appropriate rectangle that corresponds to the total time spent with the patient—see the next paragraph.)

Section VI: Minutes spent with the patient, Follow-up, Units, OMT Performed as above (number of areas), Other Procedures Performed, and E/M Code

Minutes Spent With the Patient: Blacken the rectangle that corresponds to the amount of time you spent face-to-face with the patient and/or family during their visit (10, 15, 25, 40, 60, >60 minutes). This corresponds to the time allotments in the CPT book. Choose the rectangle that best fits your total time.

Follow-up: Blacken the rectangles that correspond to when you would like to see the patient again; you must indicate both the number and the **Units**. For example: for a visit in one month, blacken the rectangle above the “**1**” and also the rectangle above **M** (month). Abbreviations following the **Units** title are: **D** (days), **W** (week), **Y** (year), and **PRN** (as needed).

OMT performed as above: Fill in the box for the number of regions with somatic dysfunction that were treated. Note: This number should correlate with the number of YES rectangles in the OMT section of the table on page 3 of 3, and the number of rectangles in the severity section of the table on page 2 of 3 marked with a 1, 2, or 3. The rectangles are defined as follows:

0 areas: You treated NO (zero) regions of somatic dysfunction with Osteopathic Manipulative Treatment.
1-2 areas: You treated one to two regions of somatic dysfunction with Osteopathic Manipulative Treatment.
3-4 areas: You treated three to four regions of somatic dysfunction with Osteopathic Manipulative Treatment.
5-6 areas: You treated five to six regions of somatic dysfunction with Osteopathic Manipulative Treatment.
7-8 areas: You treated seven to eight regions of somatic dysfunction with Osteopathic Manipulative Treatment.
9-10 areas: You treated nine to ten regions of somatic dysfunction with Osteopathic Manipulative Treatment.

Other Procedures Performed: In the spaces provided, write in the **CPT Codes** and written diagnosis **(Written Dx)** for each procedure performed, other than OMT.

E/M Code: Blacken the rectangle that corresponds to the evaluation and management code for your final level of service. For a new patient visit (**New**) use 99202, 99203, 99204, 99205. For an established patient visit (**EST**) use 99211, 99212, 99213, 99214, 99215. For a consultation visit (**Consults**) use 99241, 99242, 99243, 99244, 99245.

Signature of examiner: Signature of the attending physician is mandatory. Also, the transcriber should sign, if this is appropriate.

D: \ Sleszynski | SOAP Note Series Usage Form. Version 5: 091102cw.

Outpatient Health Summary

wak SOAP version 5: 091102b

Patient's Name Jane Doe
Date 1/1/01
Update:
Date of Birth 9/ 13/1976
Sex F
Marital Status: M [✓ S] D W
Phone Numbers: **Home** 262-657-5975 **Work** 847-595-2714
Significant Others: Boyfriend--John
DNR Status: Resuscitate? X **Yes** **No**
Qualifications:
Religion: Catholic
Next of Kin: Gordon and Shirley Smith--parents

Social History:
Employment Abbott Labs
Occupation Secretary
Education College x 4 yrs.
Tobacco Quit 1999
ETOH 2 beers per wk
Drugs past pot
Tobacco Quit 1999

Family History:
M ↑ Hypothyroid
F ↓46 yrs MI and PUD
Siblings 1 brother A & W
1 sister Asthma
Others: Maternal GM ↓ breast CA

Past Medical History

CPT#	Start Date	Problem / Diagnosis	Medications	Start	Stop
		Sciatica	Proventil inhaler PM	1999	
564.1		IBS	Advil 400 mg TID	9-01	
493.00		Asthma	Synthroid 0.125mg po qd	2000	
244.9	2000	Hypothyroidism	St. John's Wort	10-01	
	1985	MVA Ø injury	Vit. B6. E. B12. C		
250.01		DM Type I	Norflex 100 mg po BID	10/01	
847.1	10/01	Thoracic strain			

Allergies, Adverse Drug Reactions: PCN – rash Cat dander, ragweed

Health Maintenance

Parameter	Dates							
DPT/DT/TD	1976	1-77	3-77	1982	1992			
OPV	11-76	1-77	3-77	1982				
MMR	1977							
HIB	11-76	1-77	3-77					
Influenza								
Hepatitis	2-83	3-82	9-82					
PPD/Tine								
Pneumovax								
H & P	2000							
Eye exam	3 / 01							
Dental exam	6 / 01							
PAP smear	2000							
Mammogram								
Urinalysis	2000							
Hemoccult								
Cholesterol	2000/189							
Sigmoidoscopy								
Others	6-01							

Past Surgical History

Date	Type
Child	T and A
1991	Wisdom teeth x 4
1980	Sutures Rt. forearm
1993	Fx right wrist

Consultants

PCP	Inveiss
GYN	Azuma

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Outpatient Osteopathic SOAP Note History Form

wak SOAP version 5: 091102b

Office of:	
For office use only:	

Patient's Name Jane Doe **Date** 1/1/02 **Age** 25

HISTORY

S (See Outpatient Health Summary Form for details of history)

Patient's Pain Analog Scale: ☐ Not done

Back Stomach

NO PAIN WORST POSSIBLE PAIN

CC Stomach ache, back pain

Patient saw chiro—temporary relief only

History of Present Illness **Level: HPI**

☑	Location	Mostly mid-epigastric and mid-back
☑	Quality	Achy, dull
☑	Severity	See above back improved after OMT
☑	Duration	Started 2 days ago—stomach
☑	Timing	+ flare x 1 d after OMT
☑	Context	Better after eating
☑	Modifying factors	Bed rest helps
☑	Assoc. Signs and Sx	+ weakness with ↑ discomfort

Elements

OR Status of ≥ 3 chronic or inactive conditions

Blood sugars—stable

☐	II III	1-3 elements reviewed
■	IV V	≥ 4 elements OR status of ≥ 3 chronic conditions

Review of Systems (Only ask / record those systems pertinent for this encounter.) ☐ Not done **Level: ROS**

☐	Constitutional (Wt loss, etc.)	
☐	Eyes	
☐	Ears, nose, mouth, throat	
■	Cardiovascular	No palpitations
☐	Respiratory	
■	Gastrointestinal	Ø Nausea or vomiting
■	Genitourinary	No pain or burning with urination
☐	Musculoskeletal	
☐	Integumentary (skin, breast)	
☐	Neurological	
☐	Psychiatric	
☐	Endocrine	
☐	Hematologic/lymphatic	
☐	Allergic/immunologic	

☐	II	None
☐	III	1 system pertinent to the problem
■	IV	2-9 systems
☐	V	≥ 10 systems

Past Medical, Family, Social History ☐ Not done **Level: PFSH**

■	Past history / trauma	Ø trauma
	Allergies:	
	Medications:	Norflex 100 mg p o BID
■	Family history	↓ F at 46 yrs of PUD
☐	Social history	

☐	II III	None
☐	IV	1 history area
■	V	≥ 2 history areas

Overall History = Average of HPI, ROS or PFSH: ☐ **II** (1-3 HPI) ☐ **III** (1-3 HPI, 1 ROS) ☐ **IV** (4+ HPI, 2-9 ROS, 1 PFSH) ■ **V** (4+ HPI, 10+ ROS, 2+ PFSH)

Signature of transcriber:	Signature of examiner: SLSleszynskiDO

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Outpatient Osteopathic SOAP Note Exam Form

wak SOAP version 5: 091102b

Office of:	
For office use only:	

O ☐ Not done

Patient's Name Jane Doe Date 01/01/02 Sex: Male ☐ Female ☒

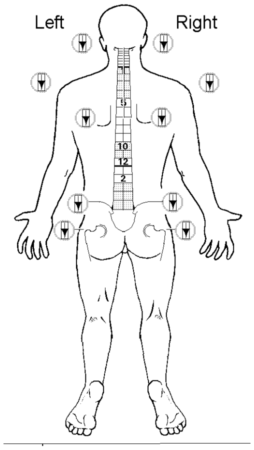
* Vital Signs (3 of 7) Wt. 130 lb. Ht. 5 ' 5 " Temp. 98.6

Reg. ☒ Pt. position for recording BP:

Resp. 20 Pulse 80 Irreg. ☐ Standing________ Sitting 120 / 80 Lying__________

Abdomen—tender epigastrium, + bowel sounds in 4 quadrants, Ø masses.

UE—Bilateral muscle strength 5 / 5.



Level of GMS

☐	II	1-5 elements
☒	III	6+ elements
☐	IV	2+ from each or 6 areas OR 12+ elements in 2+ areas
☐	V	Perform all elements ≥ 9 areas

Key to the Severity Scale

0 = No SD or background (BG) levels
1 = More than BG levels, minor TART
2 = Obvious TART (esp. R and T), +/- symptoms
3 = Key lesions, symptomatic, R and T stand out

	Methods Used For Examination					**Region Evaluated**	**Severity**				**Somatic Dysfunction and Other Systems**
	All	**T**	**A**	**R**	**T**		**0**	**1**	**2**	**3**	MS / SNS / PNS / LYM. / CV / RESP. / GI / FAS. / etc.
*1	☐	☐	☐	☐	☒	Head and Face	☐	☒	☐	☐	Parietal area tender to touch
	☒	☐	☐	☐	☐	Neck	☐	☐	☒	☐	
*2	☐	☒	☐	☐	☐	Thoracic T1-4	☐	☐	☐	☒	T3 L, Tissue texture change
	☐	☒	☐	☐	☐	T5-9	☐	☐	☐	☒	T5 R, TTC, T7L—V.S—GI related
	☒	☐	☐	☐	☐	T10-12	☐	☐	☒	☐	T10 F S R_R
	☐	☐	☐	☐	☐	Ribs	☐	☐	☐	☐	
	☒	☐	☐	☐	☐	Lumbar	☐	☐	☒	☐	Myofascial strain
	☒	☐	☐	☐	☐	Sacrum / Pelvis	☒	☐	☐	☐	WNL
	☐	☐	☐	☐	☐	Pelvis / Innom.	☐	☐	☐	☐	
	☐	☐	☒	☒	☐	Abd ./ Other	☐	☐	☐	☒	↓ mobility greater curvature of stomach
*3	☐	☐	☐	☐	☐	Upper R	☐	☐	☐	☐	
*4	☐	☐	☐	☒	☐	Extremity L	☐	☐	☒	☐	Shoulder abduction 160 degrees
*5	☐	☐	☐	☐	☒	Lower R	☐	☒	☐	☐	Tender TFL
*6	☐	☐	☐	☐	☒	Extremity L	☐	☐	☐	☐	

Signature of transcriber: ________________________

Signature of examiner: SLSleszynskiDO

Outpatient Osteopathic Assessment and Plan Form

wak SOAP version 5: 091102b

Office of:	
For office use only:	

A **Patient's Name** Jane Doe **Date** 1/1/02

Dx No.	ICD Code	Written Diagnosis	Dx No.	ICD Code	Written Diagnosis
1	535.40	Gastritis d/t irritation w/o hemorrhage			
2	847.1	Thoracic strain			
9	250.01	Diabetes mellitus Type I—controlled			
8	739.0	Somatic Dysfunction of Head and Face		739.4	Somatic Dysfunction of Sacrum
7	739.1	Somatic Dysfunction of Neck		739.5	Somatic Dysfunction of Pelvis
3	739.2	Somatic Dysfunction of Thoracic	4	739.9	Somatic Dysfunction of Abd / Other
	739.8	Somatic Dysfunction of Ribs	6	739.7	Somatic Dysfunction of Upper Extremity
9	739.3	Somatic Dysfunction of Lumbar	5	739.6	Somatic Dysfunction of Lower Extremity

Physician's evaluation of patient prior to treatment: First visit ☐ Resolved ☐ Improved ☐ Unchanged ☒ Worse ☐

P

☐ All not done	OMT		Treatment Method															Response			
Region	**Y**	**N**	ART	BLT	CR	CS	DIR	FPR	HVLA	IND	INR	LAS	ME	MFR	ST	VIS	OTH	**R**	**I**	**U**	**W**
Head and Face	☒	☐	☐	☐	☐	☐	☐	☐	☐	☒	☐	☐	☐	☐	☐	☐	☐	☒	☐	☐	☐
Neck	☒	☐	☒	☐	☐	☐	☐	☒	☐	☐	☐	☐	☒	☐	☒	☐	☐	☐	☒	☐	☐
Thoracic T1-4	☒	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☒	☐	☐	☐	☒	☐	☐
T5-9	☒	☐	☒	☐	☐	☐	☐	☐	☒	☐	☐	☐	☐	☐	☒	☐	☐	☐	☐	☒	☐
T10-12	☒	☐	☒	☐	☐	☐	☐	☐	☒	☐	☐	☐	☐	☐	☒	☐	☐	☒	☐	☐	☐
Ribs	☒	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Lumbar	☒	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☒	☐	☐	☐	☒	☐	☐	☐
Sacrum	☐	☒	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Pelvis	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Abdomen/Other	☒	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☒	☐	☐	☐	☐	☒
Upper Extremity	☒	☐	☒	☐	☐	☐	☐	☐	☐	☐	☐	☐	☒	☐	☐	☐	☐	☐	☒	☐	☐
Lower Extremity	☐	☒	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Meds: Add Prilosec 20 mg po qd

PT: Hot packs done
Heat at home to thoracic area

Exercise: Shoulder stretches given

Other: Emotional support given for 5 minutes
Obtain H. pylori and flat plate of abdomen—X-ray.

Nutrition: Bland diet

Complexity / Assessment / Plan (Scoring) *Default to level 2—same criteria

Problems		**Risk:** (presenting problem(s), diagnostic procedure(s), Management options)	**Data**	**Maximum Points**
Self-limiting	1 (2 max.)		Lab	[✓ 1]
Estimated problem improved / stable OM, back	[✓ 1]	Minimal = Min.	Radiology	[✓ 1]
Estimated—worsening.	2	Low	Medicine	[✓ 1]
New—no workup	3 (1 max.)	Moderate = Mod.	Discuss with performing physician	1
New—additional workup Stomach	[✓ 4]	High	Obtain records or Hx from others	1
			Review records, discuss with physician	2
			Visualization of tracing, specimen	2

Level I	Level II	Level III	Level IV	Level V	Level I	Level II	Level III	Level IV	Level V	Level I	Level II	Level III	Level IV	Level V
*	≤1 pt.	2 pt.	3 pt.	≥4 pt.	*	Min.	Low	Mod.	High	*	≤1 pt.	2 pt.	3 pt.	≥4 pt.
	☐	☐	☐	☒		☐	☐	☒	☐		☐	☐	☒	☐

Requires only 2 above 3 (problems, risk and data). Level of complexity = average of included areas.

Traditional Method—Coding by Components

History	I	II	III	IV	[✓ V]
Examination	I	II	[✓ III]	IV	V
Complexity / Assessment Plan	~~I~~	II	III	[✓ IV]	V
Final level of service	☐	☐	☐	☒	☐

All these areas required. Average of three levels of service.

Optional Method—Coding by Time

When majority of the encounter is counseling / coordinating, the level is determined by total time

	I	II	III	IV	V
New patients (minutes)	10	20	30	45	60
Established patients (minutes)		10	15	25	40
Final level of service	☐	☐	☐	☐	☐

Dictate total time and counseling / coordinating time plus a brief description of topics discussed

Minutes spent with the patient: ☐ 10 ☐ 15 ☒ 25 ☐ 40 ☐ 60 ☐ >60

Follow-up: ☒ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐ 11 ☐ 12

Units: ☐ D ☒ W ☐ M ☐ Y ☐ PRN

OMT performed as Above: 0 areas ☐ 1-2 areas ☐ 3-4 areas ☐ 5-6 areas ☒ 7-8 areas ☐ 9-10 areas ☐

Other Procedures Performed:					
	CPT Codes:	97010	97110		
	Written Dx:	Hot packs	Exercise		

E/M Code:	**New**					**EST**						**Consults**				
		☐	☐	☐	☐		☐	☐	☐	☒	☐		☐	☐	☐	☐	☐
Write 992 plus . . .		*02*	*03*	*04*	*05*	*. . .*	*11*	*12*	*13*	*14*	*15*	*. . .*	*41*	*42*	*43*	*44*	*45*

Signature of transcriber: ____________

Signature of examiner: SLSleszynskiDO

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Outpatient Health Summary

wak SOAP version 5: 091102b

Patient's Name		**Date**	**Update:**		
Date of Birth	**Sex**	**Phone Numbers:**	**Home**		
Marital Status: M S D W			**Work**		
Significant Others:		**DNR Status:** **Resuscitate?**	**Yes**	**No**	**Qualifications:**
Religion:		**Next of Kin:**			

Social History:	**Employment**		**Occupation**		**Education**
	Tobacco	**ETOH**		**Drugs**	**Sex Hx**

Family History:	**M**	**Siblings**	**Others:**
	F		

Past Medical History

CPT#	Start Date	Problem / Diagnosis	Medications	Start	Stop

Allergies, Adverse Drug Reactions: ____________________

Health Maintenance

Parameter	Dates							
DPT/DT/TD								
OPV								
MMR								
HIB								
Influenza								
Hepatitis								
PPD/Tine								
Pneumovax								
H & P								
Eye exam								
Dental exam								
PAP smear								
Mammogram								
Urinalysis								
Hemoccult								
Cholesterol								
Sigmoidoscopy								
Others								

Past Surgical History

Date	Type

Consultants

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Outpatient Osteopathic SOAP Note History Form

wak SOAP version 5: 091102b

Office of:	
For office use only:	

Patient's Name _________________________ **Date**________________ **Age**__________

HISTORY

S (See Outpatient Health Summary Form for details of history)

Patient's Pain Analog Scale: ☐ Not done

NO PAIN ———————————————————— WORST POSSIBLE PAIN

CC

History of Present Illness **Level: HPI**

Elements	☐	Location
	☐	Quality
	☐	Severity
	☐	Duration
	☐	Timing
	☐	Context
	☐	Modifying factors
	☐	Assoc. Signs and Sx

OR Status of ≥ 3 chronic or inactive conditions

____

____

____

☐	II	1-3 elements reviewed
	III	
☐	IV	≥ 4 elements OR status of ≥ 3 chronic conditions
	V	

Review of Systems (Only ask / record those systems pertinent for this encounter.) ☐ Not done **Level: ROS**

☐	Constitutional (Wt loss, etc.)	
☐	Eyes	
☐	Ears, nose, mouth, throat	
☐	Cardiovascular	
☐	Respiratory	
☐	Gastrointestinal	
☐	Genitourinary	
☐	Musculoskeletal	
☐	Integumentary (skin, breast)	
☐	Neurological	
☐	Psychiatric	
☐	Endocrine	
☐	Hematologic/lymphatic	
☐	Allergic/immunologic	

☐	II	None
☐	III	1 system pertinent to the problem
☐	IV	2-9 systems
☐	V	≥ 10 systems

Past Medical, Family, Social History ☐ Not done **Level: PFSH**

☐	Past history / trauma
	Allergies:
	Medications:
☐	Family history
☐	Social history

☐	II	None
	III	
☐	IV	1 history area
☐	V	≥ 2 history areas

Overall History = Average of HPI, ROS or PFSH: ☐ **II** (1-3 HPI) ☐ **III** (1-3 HPI, 1 ROS) ☐ **IV** (4+ HPI, 2-9 ROS, 1 PFSH) ☐ **V** (4+ HPI, 10+ ROS, 2+ PFSH)

Signature of transcriber: ________________________

Signature of examiner: ____

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Outpatient Osteopathic SOAP Note Exam Form

wak SOAP version 5: 091102b

Office of:	
For office use only:	

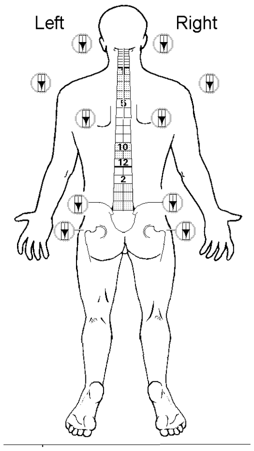
O ☐ Not done

Patient's Name ______________________ Date ________ Sex: Male ☐ Female ☐

* Vital Signs (3 of 7) Wt. ____________ Ht. ______________ Temp. _________

Reg. ☐ Pt. position for recording BP:

Resp. ____ Pulse ____ Irreg. ☐ Standing________ Sitting________ Lying__________



Level of GMS

☐	**II**	1-5 elements
☐	**III**	6+ elements
☐	**IV**	2+ from each or 6 areas OR 12+ elements in 2+ areas
☐	**V**	Perform all elements ≥ 9 areas

Key to the Severity Scale

0 = No SD or background (BG) levels

1 = More than BG levels, minor TART

2 = Obvious TART (esp. R and T), +/- symptoms

3 = Key lesions, symptomatic, R and T stand out

	Methods Used For Examination					**Region**	**Severity**				**Somatic Dysfunction and Other Systems**
	All	**T**	**A**	**R**	**T**	**Evaluated**	**0**	**1**	**2**	**3**	MS / SNS / PNS / LYM. / CV / RESP. / GI / FAS. / etc.
***1**	☐	☐	☐	☐	☐	Head and Face	☐	☐	☐	☐	
	☐	☐	☐	☐	☐	Neck	☐	☐	☐	☐	
***2**	☐	☐	☐	☐	☐	Thoracic T1-4	☐	☐	☐	☐	
	☐	☐	☐	☐	☐	T5-9	☐	☐	☐	☐	
	☐	☐	☐	☐	☐	T10-12	☐	☐	☐	☐	
	☐	☐	☐	☐	☐	Ribs	☐	☐	☐	☐	
	☐	☐	☐	☐	☐	Lumbar	☐	☐	☐	☐	
	☐	☐	☐	☐	☐	Sacrum / Pelvis	☐	☐	☐	☐	
	☐	☐	☐	☐	☐	Pelvis / Innom.	☐	☐	☐	☐	
	☐	☐	☐	☐	☐	Abd ./ Other	☐	☐	☐	☐	
***3**	☐	☐	☐	☐	☐	Upper R	☐	☐	☐	☐	
***4**	☐	☐	☐	☐	☐	Extremity L	☐	☐	☐	☐	
***5**	☐	☐	☐	☐	☐	Lower R	☐	☐	☐	☐	
***6**	☐	☐	☐	☐	☐	Extremity L	☐	☐	☐	☐	

Signature of transcriber: ______________________

Signature of examiner: ____

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Page 2 of 3

Outpatient Osteopathic Assessment and Plan Form

wak SOAP version 5: 091102b

Office of:	
For office use only:	

A **Patient's Name** ______________________ **Date** ______________________

Dx No.	ICD Code	Written Diagnosis	Dx No.	ICD Code	Written Diagnosis
	739.0	Somatic Dysfunction of Head and Face		739.4	Somatic Dysfunction of Sacrum
	739.1	Somatic Dysfunction of Neck		739.5	Somatic Dysfunction of Pelvis
	739.2	Somatic Dysfunction of Thoracic		739.9	Somatic Dysfunction of Abd / Other
	739.8	Somatic Dysfunction of Ribs		739.7	Somatic Dysfunction of Upper Extremity
	739.3	Somatic Dysfunction of Lumbar		739.6	Somatic Dysfunction of Lower Extremity

Physician's evaluation of patient prior to treatment: First visit ☐ Resolved ☐ Improved ☐ Unchanged ☐ Worse ☐

P

☐ All not done **Region**	**OMT**		**Treatment Method**															**Response**			
	Y	**N**	ART	BLT	CR	CS	DIR	FPR	HVLA	IND	INR	LAS	ME	MFR	ST	VIS	OTH	**R**	**I**	**U**	**W**
Head and Face	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Neck	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Thoracic T1-4	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
T5-9	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
T10-12	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Ribs	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Lumbar	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Sacrum	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Pelvis	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Abdomen/Other	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Upper Extremity	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Lower Extremity	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Meds: ______________________

PT: ______________________

Exercise: ______________________

Other: ______________________

Nutrition:

Complexity / Assessment / Plan (Scoring) *Default to level 2—same criteria

Problems		Risk (presenting problem(s), diagnostic procedure(s), Management options)	Data	Maximum Points
Self-limiting	1 (2 max.)		Lab	1
Estimated problem improved / stable	1	Minimal = Min.	Radiology	1
Estimated—worsening.	2	Low	Medicine	1
New—no workup	3 (1 max.)	Moderate = Mod.	Discuss with performing physician	1
New—additional workup	4	High	Obtain records or Hx from others	1
			Review records, discuss with physician	2
			Visualization of tracing, specimen	2

Level I	Level II	Level III	Level IV	Level V	Level I	Level II	Level III	Level IV	Level V	Level I	Level II	Level III	Level IV	Level V
*	≤1 pt.	2 pt.	3 pt.	≥4 pt.	*	Min.	Low	Mod.	High	*	≤1 pt.	2 pt.	3 pt.	≥4 pt.
	☐	☐	☐	☐		☐	☐	☐	☐		☐	☐	☐	☐

Requires only 2 above 3 (problems, risk and data). Level of complexity = average of included areas.

Traditional Method—Coding by Components

History	I	II	III	IV	V
Examination	I	II	III	IV	V
Complexity / Assessment Plan	~~I~~	II	III	IV	V
Final level of service	☐	☐	☐	☐	☐

All these areas required. Average of three levels of service.

Optional Method—Coding by Time

When majority of the encounter is counseling / coordinating, the level is determined by total time

	I	II	III	IV	V
New patients (minutes)	10	20	30	45	60
Established patients (minutes)		10	15	25	40
Final level of service	☐	☐	☐	☐	☐

Dictate total time and counseling / coordinating time plus a brief description of topics discussed

Minutes spent with the patient: ☐ 10 ☐ 15 ☐ 25 ☐ 40 ☐ 60 ☐ >60

Follow-up: ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐ 11 ☐ 12

Units: ☐ D ☐ W ☐ M ☐ Y ☐ PRN

OMT performed as Above: 0 areas ☐ 1-2 areas ☐ 3-4 areas ☐ 5-6 areas ☐ 7-8 areas ☐ 9-10 areas ☐

Other Procedures Performed:	CPT Codes:				
	Written Dx:				

E/M Code:	**New**	☐	☐	☐	☐	**EST**	☐	☐	☐	☐	☐	**Consults**	☐	☐	☐	☐	☐
Write 992 plus . . .		02	03	04	05	. . .	11	12	13	14	15	. . .	41	42	43	44	45

Signature of transcriber: ______________________ Signature of Examiner ______________________

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