

SOAP Chart

Student _____ Client _____ Date _____

Subjective information: If possible, record the cause, location, intensity, duration, and frequency of symptoms the client mentions, including important information from the CHI form. For example: client has stiff neck w/ \textcircled{P} \textcircled{L} supracap reg 8/10; \textcircled{L} cervical rot 45°; \textcircled{P} w/ \textcircled{L} cervical rot 6/10. If client has nothing to report, write "N/A."

Objective information: Record symptoms you notice before and during the massage session, such as guarded movement associated with an old or recent injury, level of hypermyotonia, limited mobility, sensitivity to pressure, unusual lumps, or any visible indication of pathology. For example, mod HMT \textcircled{L} suprascap reg

Write a brief description of the massage. Include all areas you massaged, especially areas associated with any symptoms the client wants you to address.

Assessment: Record changes in the client's symptoms. For example: mild \downarrow in HMT & mod \downarrow \textcircled{P} \textcircled{L} supracap reg; mod \uparrow \textcircled{L} cervical rot to 80°; mod \downarrow \textcircled{P} w/ \textcircled{L} cervical rot. Regarding the pain in this example, you could write: \textcircled{P} \textcircled{R} interscap reg now 2/10; \textcircled{P} w/ \textcircled{L} cervical rot now 1/10. If there are no changes, write "N/A."

Plan: Record what worked for this client, what did not work, what you didn't have time to do, what you or the client want to make sure you do if you see the client again, what you learned from your session with this client, and suggestions made to the client about self-care techniques or frequency of massage sessions.

If necessary, record what you consider to be inappropriate behavior by the client, or any problems you had maintaining boundaries with the client (use the back of this page if necessary):