

SOAP NOTE QUICK GUIDE

A practical reference for nursing students

S	O	A	P
SUBJECTIVE	OBJECTIVE	ASSESSMENT	PLAN
What the patient reports	What you observe or measure	What the findings indicate	What happens next

S SUBJECTIVE

What belongs here?

- Chief complaint / reason for visit
- Symptoms and symptom characteristics
- Pain rating
- Relevant history and concerns
- Pertinent negatives reported by patient

EXAMPLE Patient reports headache 7/10, nausea, and sensitivity to light.

WATCH OUT Do not put vital signs or your own observations here.

O OBJECTIVE

What belongs here?

- Vital signs
- Physical assessment findings
- Observable appearance or behavior
- Relevant labs / diagnostics
- Measurable response to care

EXAMPLE BP 124/78 mmHg; patient shields eyes from bright light; speech clear.

WATCH OUT Describe what you actually observed instead of using vague opinions.

A ASSESSMENT

What belongs here?

- Nursing problem or clinical impression
- Interpretation of relevant findings
- Patient status / response
- Priority concern when appropriate

EXAMPLE Acute pain consistent with reported migraine symptoms, supported by S + O.

WATCH OUT Do not introduce a conclusion that is unsupported by the information above.

P PLAN

What belongs here?

- Nursing interventions
- Treatments / medications as ordered
- Monitoring and reassessment
- Patient education
- Follow-up / referral / escalation

EXAMPLE Reduce stimulation, provide ordered treatment, monitor symptoms, and reassess pain.

WATCH OUT Avoid vague plans such as "continue to monitor" without saying what you will monitor.

MAKE THE FOUR SECTIONS CONNECT

A SOAP note should tell one coherent clinical story.

S SUBJECTIVE	"Headache 7/10 with nausea and sensitivity to light."
O OBJECTIVE	Patient shields eyes from bright light; vital signs stable.
A ASSESSMENT	Acute pain consistent with reported migraine symptoms.
P PLAN	Reduce stimulation, provide ordered treatment, monitor symptoms, and reassess pain.

5 QUICK RULES FOR STRONGER SOAP NOTES

1	Separate reports from observations — Patient statements belong in S; measurable and observable findings belong in O.
2	Be specific — Use concrete details such as pain 7/10, BP 124/78, or "denies vomiting" instead of vague wording.
3	Stay relevant — Include information that contributes to the clinical picture or meets the documentation requirement.
4	Check the logic — A should be supported by S + O. P should respond directly to A.
5	Follow the required format — Your instructor, program, or clinical site may require different fields, terminology, or abbreviations.

BEFORE YOU SUBMIT OR FINALIZE YOUR NOTE

- ☐ Did I clearly separate patient reports from objective findings?
- ☐ Does my Assessment reflect the information documented in S and O?
- ☐ Does my Plan address the identified problem?
- ☐ Did I document relevant details without unnecessary repetition?
- ☐ Did I follow the format and requirements provided by my instructor or clinical site?

[OwnEssays.com](https://ownessays.com) | [Free Nursing Templates](#)

Educational resource only. Follow your instructor, nursing program, or clinical site's documentation requirements. Do not use real patient-identifying information in coursework unless appropriately permitted and protected.