

SOAP NOTE TEMPLATE

Subjective • Objective • Assessment • Plan

Patient / Client: _____	Date: _____	Time: _____
Student: _____	Course / Clinical: _____	Instructor: _____

S

SUBJECTIVE | What the patient reports

Chief Complaint / Reason for Visit

History of Present Illness / Current Symptoms

Pain / Onset / Duration / Aggravating or Relieving Factors / Associated Symptoms / Pertinent Negatives

Relevant History / Patient Concerns

O

OBJECTIVE | What you observe, measure, or verify

Vital Signs | Temp: _____ HR: _____ RR: _____ BP: _____ / _____ SpO₂: _____ %

Physical Assessment / Observable Findings

Relevant Diagnostic / Laboratory Findings

Other Objective Data

A

ASSESSMENT | What the findings indicate

Nursing Diagnosis / Clinical Impression / Problem

Supporting Findings / Patient Status / Response

P

PLAN | What happens next

Interventions / Monitoring / Reassessment

Patient Education / Treatments or Medications as Ordered

Follow-Up / Referrals

ADDITIONAL NOTES

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