Name and MR# _____ or Unique clinic ID# _____

Clinical SOAP Note Format

Subjective

– The "history" section HPI: include symptom dimensions, chronological narrative of patient's complains, information obtained from other sources (always identify source if not the patient). Pertinent past medical history. Pertinent review of systems, for example, "Patient has not had any stiffness or loss of motion of other joints." Current medications (list with daily dosages).

Objective

– The physical exam and laboratory data section Vital signs including oxygen saturation when indicated. Focuses physical exam. All pertinent labs, x-rays, etc. completed at the visit.

Facts that can be verified:

Vital signs, labs, swelling, discoloration, etc.

Outside notes information

Assessment/Problem List

– Your assessment of the patient's problems

Assessment: A one sentence description of the patient and major problem

Problem list: A numerical list of problems identified All listed problems need to be supported by findings in subjective and objective areas above. Try to take the assessment of the major problem to the highest level of diagnosis that you can, for example, "low back sprain caused by radiculitis involving left 5th LS nerve root." Provide at least 2 differential diagnoses for the major new problem identified in your note.

East Asian Diagnosis/ Western

Plan

– Your plan for the patient based on the problems you've identified Develop a diagnostic and treatment plan for each differential diagnosis. Your diagnostic plan may include tests, procedures, other laboratory studies, consultations, etc. Your treatment plan should include: patient education, pharmacotherapy if any, other therapeutic procedures. You must also address plans for follow-up (next scheduled visit, etc.). Also see your Bates Guide to Physical Examination for excellent examples of complete H & P and SOAP note formats.

Acupuncture – with points used for treatment listed, Ashii points with or without e-stim

Accessory techniques preformed/location of techniques used: Tuina, cupping, gausha etc. if oils or liniments used

Number of treatments planned before reevaluation

Education information- qi gong. Diet, meditation, sleep suggestions, herbals or supplementation

https://owl.purdue.edu/owl/subject_specific_writing/healthcare_writing/soap_notes/major_sections.html

Procedure: Intake and Acupuncture treatment	Today's date: 8/14/2020
All correct equipment/supplies are present and ready for use prior to the procedure.	YES
Patient stated name and date of birth with a picture ID.	Yes -DOB 6/14/1972 - NAME: Jane Doe
Patient verbally stated the procedure (including the site and side) to be completed.	YES
Informed Consent reviewed and consistent with procedure.	YES

SUBJECTIVE: Jane Doe is a 48year old Female was referred to XXXX Department by PCP (Dr. Marcy Jones) and a copy of the report will be sent to that provider by electronic medical record.

This patient was sent for evaluation for acupuncture treatments for chronic low back pain and will perform intake face to face and acupuncture treatment #1 under their benefit year effective date Jan 1, 2020.

Ms. Doe reports she has never had acupuncture, or dry needling, but does see a chiropractor weekly for her chronic low back pain with only slight benefit to her pain she says it helps her with mood.

Presenting complaint/Prior Diagnosis: SPINAL STENOSIS OF LUMBAR SPINE, HEADACHES, and ANXIETY
Pain score (1-10) Pain score and area: B- LBP with sciatica, worse on right side, running down right buttock down UB channel to right lateral ankle reports the pain is 6/10 and jumps up when she first gets up in morning and has been ongoing since 2018 when she reports he had a bike accident. She reports monthly frontal headaches that come on a day before her mensuration flow starts but she does not have one today.
Allergies: NKA
Medications: Meloxican(Mobic)15mg 1tablet PO daily, Pregablin(Lyrica)50mg 1tablet PO daily, Fluoxetine(Prozac)20mg PO daily

Heat/Cold	Ms Doe reports her temperature is about the same as those around her. When she has pain she uses a heating pad.
Perspiration	She reports she sweats about the same as those around them.
Body pain area	Do patient have any head or body pain. If body pain what location(s). And what side. B-LBP with sciatica, worse on right side, running down right buttock down UB channel to right lateral ankle reports the pain is 6/10 and jumps up when she first gets up in morning. She reports monthly frontal headaches that come on a day before her mensuration flow starts. She reports no abdominal pain or other digestive issues.
Hunger	When it comes to hunger when is patient – she reports that she only eats because they know they should just at a mealtime.
Thirst	She reports she only drinks because she knows they should.
Temp of liquids	Her temperature preference for what she drinks is cold too cold with ice cubes.
Urination	She reports her frequency of urine more than 5times a day
Stool	She reports she has daily to 2 times daily - Bowel movements. daily or less often, with more formed stools
Vision	She reports she wears her glasses and if so do they wear them - all the time
Hearing	She reports she has ringing in the ears- like whistle and has decreased hearing on the right side.
Sleep	She reports she has difficulty falling asleep, staying asleep, and difficulty falling back to sleep once awoken, and she only hours a night do they sleep total 6.5hours including naps.
Reproductive:	When it comes to reproduction/intercourse is the patient - Still sexually active, but her partner medical issues that limit their frequency. She reports still having regular periods. LMP: 7/28/2020
Constitution:	She reports she is working as a OR nurse for Nursing temp agency

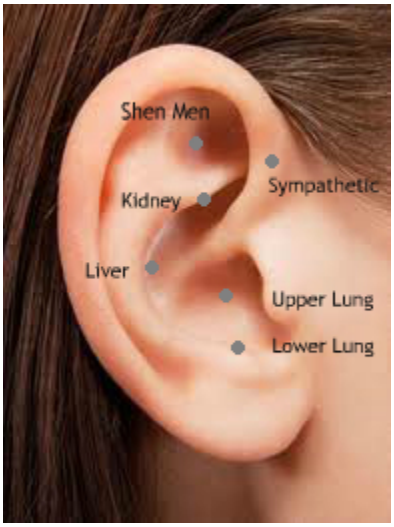
Objective:
Vitals: BP:135/77, P:59, Temp 97.9F, Resp: 16, Ht: 5'5", Wt: 108lb 4.8oz, LMP: 7/28/2020

Tongue: slight red tip, slight center crack, thin coat, darker pink tongue
Radial Pulse Right: wiry, slippery, moderate
Radial Pulse Left: wiry, slippery, moderate

Assessment/Problem List:

East Asian Diagnosis(TCM):
Root:(causes) KD/SP QI def
Branch:(acute issues) wind cold bi
Treatment Strategy: nourish kd/sp qi and release wind cold bi

Plan:
Acupuncture: Treatment with patient facedown (Prone): Right unilateral treatment: UB40, UB57, UB60, KD7, PC6, TW5, UB24, UB23, UB22, ST36, GB34, LI11, LI4, (B)GB20, DU15, ANIMEN,
Ear points (B)Shenman, Liver, Upper Lung, Kidney, Sympathetic



Needle count

Seirin
Green 6
Red 6
DBC
18x30 10
Totals 22
Sign: Dr. NCCAOM LAC

Needles removed# 22
Removed and Needle count verified by staff.

Intake and acupuncture treatment today
Four everyother week acupuncture treatments and then reevaluate at 5th visit and make new plan with adjustments if needed.

Education
Diet suggestions given
Exercises given
Neck protection suggested

Qi Gong Breathing Taught

Verbal consent for today's treatment, **sign consent on file**. **verbalized understanding of the consent and had an opportunity to have all questions answered. Risks and potential complications related to acupuncture procedures were explained to patient and understanding was verbalized.**

Prior to the treatment the possible complications of acupuncture were again reviewed as were the areas of the patient's pain and expectations of treatment.
Technique: Area identified. Acupuncture performed in typical manner.

Patient tolerated procedure well without difficulty. The treatment time was 20min discussion and education and 20 minutes needles placed.

Pain score(1-10) Post treatment: Dr Doe reports, "Wow! My pain is gone now!" and she will observe for pain relief score and will report back at next visit.

Dr. NCCAOM LAC
Clinic Address
Phone

Resources

https://owl.purdue.edu/owl/subject_specific_writing/healthcare_writing/soap_notes/major_sections.html

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