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# S-O-A-P / Progress Notes

Progress notes are made in a chart to record interactions with your patients. While they normally document what transpired during patient visits, any clinically substantive discussion by phone or outside of the clinic should be noted (a succinct summary can be entered as a telephone encounter note).The format used most often is a SOAP note. SOAP is an acronym that stands for Subjective, Objective, Assessment, and Plan.

Keep in mind that there are many potential readers of a patient's chart including other providers, insurance claim administrators, state chiropractic board peer reviewers, attorneys and the patient concerned. In order to make progress notes readable and transparent, it is important to use clear and concise prose, to avoid jargon and obscure abbreviations and to make your clinical reasoning explicit to the most naïve reader.

Shared electronic record systems, such as the Oregon Collaborative Health Information Network (OCHIN) used by UWS, allow the patient's other OCHIN providers immediate and complete access to all of your notes. Notes that are professional, clear, precise and succinct will contribute significantly to shared patient management.

*The primary purpose of a progress note, however, is to allow another practitioner to readily assume the management of a patient if you are not available ("dead doctor rule").*

**Snapshot:**

**Before the patient visit**

Review prior SOAP notes and the Care Coordination Notes (in the EPIC system), and have a plan for what you want to accomplish during the upcoming patient encounter.

**What to record in each section of a SOAP**

**S**: Clinically pertinent things that the patient tells you (except how they respond to today's treatment).

**O:** Clinically pertinent observations that you obtain by your clinical examination on that patient visit.

**A:** YOUR assessment of how the patient is progressing (based upon your impression of their subjective plus objective data from prior visits).

**P:** Today's treatment, treatment response, and any plans for future care.

**When to immediately notify a clinician**

1) If the patient has a new problem, a re-injury, or exacerbation of a current problem.
2) If the patient gets worse as a result of the treatment.
3) Before making referrals to any other provider, clinic or agency.
4) Before recommending diet plans, supplements or changes in medications.

The SOAP format can be used for new patients, new problems in a current patient, and routine care. This protocol will focus on routine care visits.

## UWS Clinics

Check with your supervising clinician to see which elements of the SOAP should routinely be completed prior to securing permission to treat during any given visit.

**Clinic Requirement:** Before treating a patient you must, at minimum, review the previous SOAP note(s) and the Care Coordination Notes in EPIC. In order to direct the therapeutic encounter, it is appropriate to review each patient's care to date and formulate a plan for that particular visit. Have a clear idea of what you want to accomplish in that patient encounter and how it fits into your overall management plan for the patient and his/her problems.

**Clinic Requirement:** The entire SOAP should preferably be completed by the end of that patient visit or soon thereafter to ensure accuracy. It must be completed no later than the end of the shift. In some circumstances, your supervising clinician may extend this deadline to the end of the next work day.

If a change or addition is be made to a SOAP note once it is a closed encounter, it must be done as an addendum and routed to your clinician.

**A Word on Paper charts:** In practice if paper charting is done, use black ink and write legibly. Every entry must be signed and dated. If working with paper charts, any change or correction to a SOAP note must be initialed and dated. Any words struck out must be with a single line so that the original wording is still legible. Addenda can be added at a later date, but they must also be approved by a clinician and initialed and dated. The addendum must be clearly referenced as to which SOAP entry is being revised.

# S = SUBJECTIVE

Under S, record the subjective information provided by the patient. You must track the course of the condition you are treating, including the patient's response to therapy rendered at the previous visit. If you are managing more than one problem during that visit, be sure to clearly separate them in your notes.

**Clinic Tip:** Note that in the EHR system some of the data for the S section may be outside the SOAP screen (e.g., OPS / (Wong Baker FACES Scale, PSFS).

One good strategy is to use consistent interview questions, repeated at each visit, in order to determine the patient's degree of change, their satisfaction with care, their compliance with self-care and lifestyle recommendations and to uncover barriers to recovery. For example, the following, or similar questions, can be used to initiate the encounter:

- How do you feel now compared to before you started treatment?
- Have you reached your treatment goals; are you satisfied with the results of the treatment?
- Have you learned/practiced any self-care strategies?
- Do you feel confident about managing the problem on your own?

Record the patient's input by starting with a phrase such as "the patient reports" or "Mrs. Smith states." Avoid using a conversational tone like "the patient is doing great." Be sure not to limit your report to a simple "patient is feeling better." As you continue the encounter, you should focus on specific outcome measures. The following are key elements to record for each problem:

- **Changes in the condition.** Find out if the patient is better, worse, or the same since beginning care (and/or since the last visit). If there has been a re-injury or specific incident causing an exacerbation, record the pertinent information. In these cases, notify the clinician immediately.

- **Treatment response.** Another very important, but distinctly separate question, is how the patient responded to the last treatment, including the immediate response (24-48 hours). If the effects were temporary, record the length of time the improvement or side effect lasted.

- **Outcome measures.** Utilizing the outcome measures indicated in the treatment plan, record the patient's subjective progress relative to function and/or symptom intensity:

  **Effects on job, recreation and/or ADLs.** If you are measuring effects on ADLs, the Patient Specific Functional Scale (PSFS) is recommended. Otherwise, chart the frequency, duration, and intensity of symptom response for specific activities that you have previously identified. For example, if you are using walking as an indicator, you might record how far or how long the patient has been able to walk, how long the pain/increased pain lasted due to the walking, and the increase in symptom severity.

**Clinic Tip:** If you have used a written questionnaire such as the NDI or Oswestry, your clinical supervisor may direct you to administer it multiple times before the next formal re-evaluation. If so, you will need to record the score in the SOAP and add it to the DOC Flow Sheet field.

  **Symptom changes.** If you are monitoring pain intensity, make sure to quantify it by using an oral pain scale (OPS), the Wong-Baker FACES scale, a visual analogue scale on a form (VAS) and/or analgesic use. You can track current pain, average pain, peak/least pain or all three parameters. Other pain features that are useful to chart are pain centralization or peripheralization, and if sharp neurologic pain changes in character. When recording the intensity of other types of symptoms (e.g., stiffness, dizziness), indicate the symptom and the intensity on a 10 point scale (e.g., dizziness 4/10). In the case of episodic conditions, track frequency and duration of the episodes; in cases where patients report of constant pain, track the percentage of the day or week that the patient is pain free or has pain.

  NOTE: It is recommended *not* to use pain as either the sole measure or even the first measure to discuss with the patient during office visits —this is especially true in chronic pain conditions.

**Practice Tip:** Remember that when monitoring progress, you cannot compare numerical values measured by different instruments (e.g., you cannot compare a verbal pain value with the one taken from a visual analogue scale or a 5 point FACES scale).

- **Compliance.** In addition, you may include any pertinent information regarding whether the patient has been following your home treatment plan. Record any barriers to compliance and any strategies that the patient has adopted in order to get past them.

**Identify each problem**. If the patient has multiple problems that are tracked or respond differently, please identify each separately by diagnosis, problem, or ICD code.

If the patient has a new problem, a re-injury, or exacerbation of a current problem, you *must* immediately notify your supervising clinician who will direct how much additional history needs to be taken.

# O = OBJECTIVE

Objective data is essentially anything you observe, palpate or test in the office during that visit. This data provides a way of verifying diagnoses, demonstrating change or stasis in response to the treatment and providing evidence for the necessity of the treatment provided to the patient that day. The O should be written in such a way that if asked to demonstrate the medical necessity for the treatment rendered on that day, there would be appropriate objective findings to support the therapy.

- **General appearance.** If appropriate, general observations about the patient's physical presentation (e.g., antalgic posture, gait disturbances, patient looks ill, has guarded movements, etc.). Observation includes how the patient enters the treatment room, moves, and gets on and off the adjusting table, uses a cane or crutches, etc.

- **Affect, demeanor, responsiveness.** Your patient's mood, demeanor, level of cooperation, ability to engage in dialogue and cognitive functioning are all pertinent and frequently important observations to record.
- **Outcome measures.** Physical findings that you are monitoring to gauge improvement (i.e., the objective outcome measures that you have identified in your management plan appropriate to the current phase of care). Examples include specific measurements (e.g., global AROM, blood pressure, limb girth), functional tests (e.g., static low back endurance test), certain orthopedic test results (e.g., SLR), or neurological findings.
- **Findings to support treatment.** Physical findings used to support your treatment such as joint dysfunction listings (listings may be written a variety of ways as taught in the Practice and Principle classes, tender points (remember to use the tenderness grading scale when appropriate), swelling/edema, key movement patterns, functional tests (e.g., watching the quality of movement as a patient rises from a chair). Although these are generally considered weak outcome measures because they do not consistently correlate with overall global improvement (i.e., decreased symptoms, improved function, patient satisfaction), they are necessary to support various components of care and to indicate when a particular *therapeutic objective* has been reached (e.g., decreased sensitivity to pain, improved range of motion, decreased spasm, improved motor control).

**Clinic Tip:** It is important to record when examination procedures reproduce the patient's familiar pain, to record where the point of maximum tenderness resides with palpation, and to rate the degree of severity when pain is produced.

- **Two of the following objective findings must be present to establish therapeutic necessity for CMT.** One of the two must be "A" or "R."

  **P:** Pain/tenderness (may include location, quality, intensity, grade of tenderness).

  **A:** Asymmetry/misalignment sectional or segmental. The static palpation listing can capture this information.

  **R:** Range of motion abnormality (active/passive global or segmental). Listings can be used to capture this motion palpation information.

  **T:** Tissue/tone changes (temperature, color, swelling, spasticity, etc.).

**Practice Tip:** A third party payer or the state Chiropractic Board may request your chart notes. It is important that each SOAP entry always contains sufficient, appropriate objective findings to justify each distinct treatment procedure (e.g., manipulation, physical therapy modalities, strengthening exercises, soft tissue therapy, motor control exercises). This justification is referred to as establishing "therapeutic" or "medical necessity" and is vital for reimbursement and may also be important to fulfill local chiropractic statutes or administrative rules.

On routine visits, however, it is usually not necessary to perform ALL of the tests that had significant findings from the initial intake exam.

If the patient has multiple problems, please identify each separately with its proper diagnosis.

# A = ASSESSMENT

In many ways, this is the heart of a SOAP note—the place where the doctor's reasoning is recorded. Reflections on therapeutic failure, problem solving, identifying barriers to recovery and analyzing the outcome of therapy are the appropriate elements of clinical reasoning. These provide a rationale for continued care or changes in therapeutic direction.

This portion has two key elements: the first consists of the diagnoses being managed on that visit and the second is the assessment of the patient's overall progress. No other information should be in this section of the SOAP.

**Clinic Requirement:** If you wish to change, modify or resolve a diagnosis, be sure to discuss this with your clinical supervisor before committing to the change in writing.

In order to make a coherent assessment of a patient's status and progress in response to care, first consider the category of care and the intent of the care being provided.

Medically necessary or therapeutic care is meant to lead to significant, lasting progress toward a realistic, measurable goal within a specified, reasonable time interval.

For patients receiving therapeutic care, the assessment should include a comparison of their initial and current values for questionnaire scores, Patient Specific Functional Scales, physical performance measures (e.g. AROM, muscle endurance tests, etc.) and changes in activity tolerance.

For patients receiving maintenance, elective, or convenience care that is not as strongly oriented toward achieving measurable gains or prompt progress toward specific therapeutic endpoints, the focus may more appropriately be on stating the patient's progress since the previous visit.

In either case, your clinical conclusions should be based on the information from the outcome measures that you are tracking in the S and the O sections of the prior SOAP notes as well as the findings on the day of the encounter.

**Example:**

> *"Impingement syndrome: 20% improvement in AROM and pain overall, no change from last tx. Expect further improvement with continued corrective care."*

- Start by identifying the problems or problems you are managing on this visit (e.g., by diagnosis, ICD code, region of compliant).
- Indicate whether the patient's condition is progressing or not. This is a global assessment and is *your* opinion which, in turn, is corroborated by the results of the outcome measures contained in both the "S" and "O" portions of the SOAP. This assessment may influence your current treatment and future plans based on whether the patient is responding to care as expected or not.
- Overall you need to reflect if the patient is improving, worsening, maintaining improvement, demonstrates a pattern of exacerbations and remissions, or has not yet exhibited any change (e.g., "same"). In cases of true palliative/supportive care where symptom control is the goal as opposed to overall resolution of the problem, indicate whether patient continues to respond to care[†].
- In uncomplicated cases, you can readily give an explicit summary which would include the main data or reason that you believe the patient is improving or not improving. See Table 1 for examples. If the problem is worsening, please explain (and alert the supervising clinician).

[†] It is important not to mischaracterize therapeutic care as palliative/supportive care because most 3rd party payers do not reimburse for palliative care and chiropractic boards may bring an action because of overutilization.

**Table 1: Sample Assessment Statements**

| **Brief assessments** |
|---|
| "50% subjective & objective improvement." |
| "No change since last visit, maintaining 50% improvement since injury." |
| "Continued improvement in P and PSFS." |
| "LBP ↓, SLR increased 20%, flexion AROM ↑ 25 degrees." |
| "Patient continues to experience exacerbation & remissions." |
| "No change in daytime P, patient sleeping better, neuro deficits remain unchanged." |
| "Patient improving. Post tx P relief lasting longer, now 2-3 days." |
| "Progressing as expected; can stand and walk longer periods." |
| "R Ankle improving, swelling down, pain now only when walking." |
| "L Knee remains pain free, strength improved, motor control still poor." |
| "Slow steady improvement." |
| "No change in patient's condition." |
| "Patient responding according plan." |
| "Patient experiences short term symptom response." |
| **Longer assessments** |
| Chronic neck pain: Mr. ____has had minimal lasting improvement since starting treatment for neck and back pain on x/xx/xx. Pain intensity has decreased from 4/5 to 2/5. He self-rates global improvement at 10%. The Neck Disability Index shows only a 2% change (far below the MCID) after 5 treatments. No performance measures have been monitored consistently.<br>He's had no reported increases in physical activity or activity tolerance. He's likely reached the Maximum Therapeutic Benefit for passive therapy alone.<br>He may benefit from focusing on a challenging core stabilization approach and on increasing moderate to intense physical activity. |
| Acute LBP: Improving quickly. Patient self rates her improvement at 20% since first visit and is going to try and work out this week. Her Revised Oswestry Questionnaire has decreased by 10% and VAS has gone down by 2 cm. |
| Chronic LB and Neck Pain Mr. _____has had minimal progress after eight treatments. He rates his overall improvement at 10%. His cervical and lumbosacral active range of motions have improved slightly with continued pain and guarding. His Neck Disability Index score has improved slightly (8%) but Revised Oswestry Pain Questionnaire has not changed. These changes are below the usual threshold for minimal clinically important differences and the treatment has been ineffective. |
| Acute LBP: The outcome measures indicate that the patient is nearly recovered: ROQ dec, from 60% to 22%, PSFS inc. from 2 to 6, Rep. Sit Up test inc. from 6 to 20, and he has returned to full-time work (prev. missed three days). |

- **Clinic Tip:** If your patient undergoing therapeutic/corrective care has shown no improvement over 3 consecutive visits, be sure that you alert your clinical supervisor. S/he will help you judge whether this is to be expected based on the type and duration of the patient's problem.

- **REIMBURSEMENT RED FLAG:** Continued treatment with no overall progress over time defaults to maintenance care and is not reimbursable by most carriers (including Medicare). So improvement must be clearly documented. *NOTE: Improvement in symptoms intensity alone is often insufficient to demonstrate improvement.*

# P = PLAN

The "P" section of SOAP notes contains the treatment rendered during the visit, as well as a variety of other information (see table below).

**Elements of care contained in the Plan**

- Today's treatment (including rationale)
- Immediate response to treatment
- When the patient is to return
- Patient instructions
- Other important discussions (including PARQs and report of findings)
- Future plans
- Notes indicating results of x-rays, ancillary tests, medical records
- Goals and outcome measures for a new problem or for a problem re-assessment

Record the treatment that you rendered at this visit and the rationale for that treatment. Wherever appropriate, it is important to clearly indicate whether the procedure was performed on the left or right side (especially when affecting extremities).

**Example from a shoulder case: a portion of the P (rationale is in bold italics)***

Pulsed 30% US 1Mhz, 0.8W/cm2, R shoulder, x 6 minutes, to *decrease swelling*
CMT to above listings *to restore shoulder motion*
IASTM‡ to R external rotators and deltoid *to reduce adhesions* x 1 minute
Supervised wand & isometrics exercises to *improve motion & prevent atrophy* x 15 minutes

Good release with CMT, patient reports improved movement.

**REIMBURSEMENT RED FLAG:** A treatment intervention without *a stated treatment rationale*.

When manipulating segments that are not symptomatic (based on history) nor in the region of the chief complaint, it is especially important to include a rationale.

In a knee case for example, you may wish to adjust the ankle "to decrease internal rotation load on the knee." Or in a cervicogenic headache case, if you adjust the low back you might need to state "Lumbar and SI CMT to normalize spine and decrease stress on neck," or "…to remove segmental problems contributing to postural component of HA," or "…to decrease painful cervical compensation." In the case of manipulating the spine to decrease the occurrence of dysmenorrhea, you might write "…to decrease the intensity of episodes of painful menses."

* Placing the actions and rationales in a list, with one intervention per line rather than as running copy, may make it easier for clinical supervisors and chart reviewers to read. Check with your clinical supervisor to see how s/he prefers you to record this information.

‡ IASTM = Instrument assisted soft tissue manipulation

**Clinic Requirement:** If the problem list does not include a particular area (symptomatic or non symptomatic), then you must receive specific approval from your clinician before treating that area.

**Practice Tip:** Generally you cannot bill 3rd party payers for full spine or extremity adjusting in cases where the symptoms are localized (e.g., for a patient with neck pain, you may be able to charge for cervical and thoracic manipulation, but not lumbar or pelvis). In some instances when the patient is not progressing satisfactorily, you may charge for manipulation outside the symptomatic region but you must chart assessment procedures for the additional regions and provide a reasonable rationale (e.g., a cuboid joint dysfunction is altering gait mechanics in such a way that it is aggravating a patellofemoral pain syndrome).

## Record Individual Therapeutic Procedures

**Clinic Requirement:** Except for therapeutic taping (when it is a stand-alone procedure) and joint manipulation, a notation of the number of minutes spent for each therapy is required (i.e., for soft tissue manipulation, hot/cold or electrical modalities, exercise therapy, and patient education).

- **Chiropractic manipulative therapy (CMT).** Indicate whether you think your adjustment had an **immediate** local therapeutic effect. A therapeutic effect might be a change in segmental tenderness, spasm, or restored motion (upon immediate re-palpation). In some cases, it is advisable to write a comment about the method of adjustment (e.g., if a patient poorly tolerates supine thoracic adjustments, note that the adjustment was done prone; in the case of an osteoporotic patient, you might note that a rib adjustment was done by "CMT with instrument"; note if drop table or blocking is selected for a particular reason). Epic *TIP:* If a certain type of manipulation is particularly helpful or should be avoided, add this to the Care Coordination note; if definitely contraindicated, add a chiropractic treatment alert.

  **Practice Tip:** Documenting any treatment modifications made during a particular visit is *extremely important* in higher risk patients (e.g., osteoporosis, cervical disc herniations with radicular syndrome).

- **Soft tissue manipulation (STM).** List the muscle (e.g., piriformis) or muscle group (e.g., external rotators) and the mode of treatment (e.g., stripping, cross-fiber, hold-relax, PIR, etc.). Make a notation of the number of minutes spent.

- **Physical therapy modalities.** You will need to write specific parameters. For modalities like heat and ice, record the time (e.g., ice pack for 10 minutes) and location. For other therapies record the time, intensity (all of the appropriate parameters), and location. For example: "1 Mhz 30% pulsed US 1.0 W/cm$^2$, 8 mins. right shoulder to reduce edema."

➢ **REIMBURSEMENT RED FLAG:** Two modalities used on the same day for the same condition that have exactly the *same* treatment effect may not be eligible for reimbursement.

- **Exercise therapy.** When teaching or supervising therapeutic exercise, indicate briefly what you did. A list of exercises or the name of an exercise is not adequate to demonstrate time spent teaching, practicing, correcting or instructing exercise. It is necessary to state that you instructed or supervised the activity along with the rationale or expected therapeutic benefit.

**Practice Tip:** When billing for exercise instruction, a commonly used time-based code is therapeutic exercise (one or more areas, 97110). Your eligibility for reimbursement would depend, in part, on proper documentation of the procedure, the rationale (and appropriate diagnosis) for performing it, and the time spent performing it. The rationale for therapeutic exercises is to develop strength and endurance, improve range of motion and flexibility.

- **Patient education.** If patient education/counseling is done, make an entry in the SOAP note (i.e. diet change, smoking/ETOH/drug cessation, stress management, fall prevention, hypertension, cardiac risk). Include the time.

- **Also record the patient's immediate response to treatment.** Ask your patients how they feel as a consequence of the treatment *you just provided* (post treatment symptoms). Note if there are any objective changes (post-treatment signs). For example, you may wish to re-check a specific outcome measure that you have been tracking (e.g., PSFS, key movement pattern). *Your SOAP provides a place to record this under* "Post-tx Assessment."

  For the purposes of risk management, this post-treatment check allows you to record that the patient's immediate response was good. Rather then simply recording "good," the favorable response should be characterized as "↓P" or "easier global motion" or whatever specific improvement the patient noted. If measureable, you may include a number. If there is no detectable post treatment change, record that the treatment was "well tolerated." On the other hand, if there is an adverse treatment response, it allows you to offer (and record) advice to the patient (e.g., "ice when you go home" or "if this gets worse, call the clinic").

**Clinic Requirement:** Be sure to describe the adverse reaction and *immediately* notify your supervising clinician before the patient leaves the clinic.

Occasionally, you will identify patients who leave your office feeling and moving well, but who return for the next appointment having relapsed to the initial state of dysfunction and pain. If you have documented in the "S" section of the SOAP the relapse, and in the P section, the immediate favorable response to treatment, you are in a good position to recognize this pattern and to pursue it with more questions: "You feel good when you leave, but worse later—is there anything you may be doing between visits that may aggravate the problem?"

**Clinic Requirement:** If you are introducing a new treatment procedure that the patient has not experienced before or you are going to adjust an area of the body that you have not already received the patient's permission to treat, you must obtain specific permission from your clinician to add this treatment. Then you must explain the procedure, the risks or side effects, the alternatives, and ask if the patient has any questions before applying this new procedure. Mark PARQ in your SOAP next to the procedure. You may record an additional explanation if necessary. Epic *TIP*:: Use Quick Questions tab.

- **Patient to return (PTR)**. Record when you wish the patient to return for care. If the patient cannot come in at the interval you recommend, be sure to record what *your* recommendation was, and then you can also note when the patient states they will return. NOTE: "Return as needed" means that the phase of treatment has shifted from regularly scheduled care to care based on an exacerbation of symptoms as decided by the patient. Epic *TIP*: The date of return must be entered into the "Follow-up" section in Epic so that the front desk will know when they need to schedule the patient. The Comment Box can be used to indicate the need to schedule a special room, extended time, x-rays, etc. for the next visit.

**Clinic requirement:** Do not use "return as needed" without first checking with your clinical supervisor to see if this is appropriate.

- **Patient self-care instructions**. Record any activity modification recommendations, exercises, or other home care advice you give the patient, or simply record that you reminded them to continue with the home-care plan that has already been laid out. Epic *TIP*: This can be added to Patient Instructions.

- Other important discussions. If there is an important discussion with a patient regarding a concern the patient has, his or her desire for additional testing, or a discussion of alternative treatments, be sure to succinctly capture the essence of the conversation even if no further action is taken. Indicate that PARQ and report of findings were given and that the patient consented to care for a new problem or new therapy. Consider adding any substantive points of discussion in high risk patients. Epic TIP: PARQ can be recorded in Quick Questions.

- **Future plans**. If there is something you wish to examine or treat, or a test you wish to order on a future visit, this is a good place to record that information. Epic *TIP*: This can also be recorded in Follow Up.

- **New and updated management plans**. You may record a management plan for a new problem and any additions or changes to the initial plan. When using a goal oriented, problem solving approach to care, it is important to include realistic, well-defined, measurable goals that can be reached in a specific time frame. These goals should be clearly and explicitly related to clinically pertinent, valid, reliable, readily trackable outcome measures.

  **Example – Initial Plan:**

  **Goals** are to decrease pain and improve activity tolerance.

  **Outcome markers**: ROQ- Initial: 51%, Current 34% (Goal <25%). Repetitive Squat and Rise: Initial 9 reps. Current - 16 reps (> 33 reps). Repetitive Sit ups Initial 1 rep. (Goal>23 reps).

This type of plan can be readily updated from visit to visit and provide an ongoing demonstration of treatment effect or signal the need for therapeutic changes in non-responders.

**Example - Follow up Visit Plan:**

**Initial Goals** to decrease pain and improve activity tolerance have been met. Current goal is to continue with core stabilization to prevent recurrences. He's had significant improvement and will be transitioned to self-care 2 more treatments.

**Outcome markers**: ROQ- Initial: 51%, Current 12% (Goal <25%). Repetitive Squat and Rise: Initial 9 reps. Current – 26 reps (> 33 reps). Repetitive Sit ups Initial 1 rep., 25 reps. (Goal>23 reps).

Epic *TIP*: In the clinics' electronic health record, a simple template has created to expedite charting of a treatment plan. The content of the template may vary according to each patient's presentation and the stage of care.

**Example I:**

Treatment in this clinic for above diagnosis(es) will include ***
Goals of treatment will be ***
Outcome markers used to assess progress will be ***

**Example II:**

**Treatment Plan**: PTR: 1 X / week for 5 weeks.
**Treatment Goals:**
1) Decrease *** pain. Current VAS score ( {1-10})
2) Activity goal: ***. Current questionnaire score: *** (indicates {MILD/MOD/SEV} effect of *** on activities)
3) Physical rehab/exercise goal: ***

**Outcome Markers (Target Goals):**
1) VAS Initial: *** Current *** (Goal <***).
2) ***Questionnaire: Initial: *** Current *** (Goal <***).
3) Performance measure(s): Initial: *** Current *** (Goal <***).



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## Revised 2013

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