II. Progress Notes

Once therapy has begun, client performance must be documented on an ongoing basis. Progress notes are short and are written during or after each session. They may be filed in a patient's medical chart, a client's folder, or written on the therapy plan itself. Daily notes serve at least three important functions: (a) they enable the clinician to monitor the treatment program on a continual basis and implement any necessary changes immediately; (b) they provide information on a daily basis to other professionals who also may be working with the client (e.g., occupational therapist, social worker); and (c) they facilitate the continuity of treatment by allowing another clinician to provide services in the event of unexpected clinician absence.

One common format of daily progress notes, particularly in medical settings, is known as SOAP notes. SOAP is an acronym that refers to the terms *S*ubjective, *O*bjective, *A*ssessment, and *P*lan.

SUBJECTIVE: Write your opinion regarding relevant client behavior or status in a brief statement.

OBJECTIVE: Record data collected for each task during the therapy session.

ASSESSMENT: Interpret data for current session and compare to client's previous levels of performance.

PLAN: Identify proposed therapy targets for the next session.

Example

S: Fred appeared tired and reluctant to cooperate with the tasks presented.

O: final /k/ in single words = 85% (17/20); plural /s/ in spontaneous phrases = 50% (20/40).

A: Fading of clinician model to a 5:1 ratio on plural task may have been premature. Today's score of 50% constitutes a decrease in accuracy compared to Fred's performance of the same task over the two previous sessions (70% and 75%).

P: Continue work on both tasks at the same levels, but decrease clinician modeling for the plural task to a 2:1 ratio.