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### Outpatient Health Summary

**Patient's Name**

**Date of Birth**

**Sex**

**Phone Numbers:**

**Marital Status:**

**Significant Others:**

**DNR Status:**

**Religion:**

**Social History:**

**Employment**

**Occupation**

**Education**

**Tobacco**

**EtOH**

**Sex Hx**

**Family History:**

**Siblings**

**Others:**

### Past Medical History

<table>
<thead>
<tr>
<th>CPT#</th>
<th>Start Date</th>
<th>Problem / Diagnosis</th>
<th>Medications</th>
<th>Start</th>
<th>Stop</th>
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</thead>
</table>

### Allergies, Adverse Drug Reactions:

### Health Maintenance

<table>
<thead>
<tr>
<th>Parameter</th>
<th>Dates</th>
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</thead>
<tbody>
<tr>
<td>DPT/DT/TD</td>
<td></td>
</tr>
<tr>
<td>OPV</td>
<td></td>
</tr>
<tr>
<td>MMR</td>
<td></td>
</tr>
<tr>
<td>HIB</td>
<td></td>
</tr>
<tr>
<td>Influenza</td>
<td></td>
</tr>
<tr>
<td>Hepatitis</td>
<td></td>
</tr>
<tr>
<td>PPD/Tine</td>
<td></td>
</tr>
<tr>
<td>Pneumovax</td>
<td></td>
</tr>
<tr>
<td>H &amp; P</td>
<td></td>
</tr>
<tr>
<td>Eye exam</td>
<td></td>
</tr>
<tr>
<td>Dental exam</td>
<td></td>
</tr>
<tr>
<td>PAP smear</td>
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<tr>
<td>Mammogram</td>
<td></td>
</tr>
<tr>
<td>Urinalysis</td>
<td></td>
</tr>
<tr>
<td>Hemoccult</td>
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</tr>
<tr>
<td>Cholesterol</td>
<td></td>
</tr>
<tr>
<td>Sigmoidoscopy</td>
<td></td>
</tr>
<tr>
<td>Others</td>
<td></td>
</tr>
</tbody>
</table>

### Past Surgical History

<table>
<thead>
<tr>
<th>Date</th>
<th>Type</th>
</tr>
</thead>
</table>

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Designed to coordinate with the Established Outpatient Osteopathic SOAP Note Form. Recommended by American Association of Colleges of Osteopathic Medicine.
### Outpatient Osteopathic SOAP Note History Form

| Patient’s Name _________________________ Date________________ Age__________ |
|------------------------------------------|-----------------|

**HISTORY**

(See Outpatient Health Summary Form for details of history)

**Patient’s Pain Analog Scale:** ☐ Not done

### CC

**Section I**

### History of Present Illness

- **Location**: 
- **Quality**: 
- **Severity**: 
- **Duration**: 
- **Timing**: 
- **Context**: 
- **Modifying factors**: 
- **Assoc. Signs and Sx**

**Review of Systems (Only ask / record those systems pertinent for this encounter.)** ☐ Not done

#### Level: HPI

<table>
<thead>
<tr>
<th>Location OR Status of ≥ 3 chronic or inactive conditions</th>
<th>II</th>
<th>III</th>
<th>IV</th>
<th>V</th>
</tr>
</thead>
<tbody>
<tr>
<td>1-3 elements reviewed</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>≥ 4 elements OR status of ≥ 3 chronic conditions</td>
<td></td>
<td></td>
<td></td>
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#### Level: ROS

<table>
<thead>
<tr>
<th>Constitutional (Wt loss, etc.)</th>
<th>II</th>
<th>III</th>
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<tbody>
<tr>
<td>None</td>
<td></td>
<td></td>
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<table>
<thead>
<tr>
<th>Eyes</th>
<th>II</th>
<th>III</th>
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<tbody>
<tr>
<td>1 system pertinent to the problem</td>
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<table>
<thead>
<tr>
<th>Cardiovascular</th>
<th>II</th>
<th>III</th>
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<tbody>
<tr>
<td>2-9 systems</td>
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<td></td>
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<table>
<thead>
<tr>
<th>Respiratory</th>
<th>II</th>
<th>III</th>
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<tbody>
<tr>
<td>≥ 10 systems</td>
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<table>
<thead>
<tr>
<th>Gastrointestinal</th>
<th>II</th>
<th>III</th>
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<td>None</td>
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<tr>
<th>Genitourinary</th>
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<th>III</th>
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<table>
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<tr>
<th>Musculoskeletal</th>
<th>II</th>
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<tr>
<td>None</td>
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<table>
<thead>
<tr>
<th>Integumentary (skin, breast)</th>
<th>II</th>
<th>III</th>
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<tr>
<td>None</td>
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<table>
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<table>
<thead>
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<th>Hematologic/lymphatic</th>
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<th>III</th>
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</table>

<table>
<thead>
<tr>
<th>Allergic/immunologic</th>
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### Past Medical, Family, Social History ☐ Not done

#### Level: PFSH

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<thead>
<tr>
<th>Past history / trauma</th>
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<table>
<thead>
<tr>
<th>Allergies:</th>
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<td>1 history area</td>
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<table>
<thead>
<tr>
<th>Medications:</th>
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<tbody>
<tr>
<td>≥ 2 history areas</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Family history</th>
<th>II</th>
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</thead>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Social history</th>
<th>II</th>
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</tr>
</thead>
<tbody>
<tr>
<td>None</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Overall History = Average of HPI, ROS or PFSH:** ☐ II (1-3 HPI) ☐ III (1-3 HPI, 1 ROS) ☐ IV (4+ HPI, 2-9 ROS, 1 PFSH) ☐ V (4+ HPI, 10+ ROS, 2+ PFSH)

Signature of transcriber: ________________________ Signature of examiner: ________________________
Outpatient Osteopathic SOAP Note Exam Form

Section I

Patient's Name ___________________ Date ___________ Sex: Male □ Female □

* Vital Signs (3 of 7) Wt. ____________ Ht. ______________ Temp. ____________

Reg. □ Pt. position for recording BP:

Resp. ___ Pulse ___ Irreg. □ Standing______ Sitting______ Lying_________

Section II

Level of GMS

□ II 1-5 elements
□ III 6+ elements
□ IV 2+ from each or 6 areas OR 12+ elements in 2+ areas
□ V Perform all elements ≥ 9 areas

Section III

Methods Used For Examination

Key to the Severity Scale

Region Evaluated

0 = No SD or background (BG) levels
1 = More than BG levels, minor TART
2 = Obvious TART (esp. R and T), +/- symptoms
3 = Key lesions, symptomatic, R and T stand out

Somatic Dysfunction and Other Systems

MS / SNS / PNS / LYM. / CV / RESP. / GI / FAS. / etc.

*1 □ □ □ □ □ Head and Face 0 □ □ □
□ □ □ □ □ Neck 0 □ □ □
□ □ □ □ □ Thoracic T1-4 0 □ □ □
□ □ □ □ □ T5-9 0 □ □ □
□ □ □ □ □ T10-12 0 □ □ □

*2 □ □ □ □ □ Ribs 0 □ □ □
□ □ □ □ □ Lumbar 0 □ □ □
□ □ □ □ □ Sacrum / Pelvis 0 □ □ □
□ □ □ □ □ Pelvis / Innom. 0 □ □ □
□ □ □ □ □ Abd. / Other 0 □ □ □

*3 □ □ □ □ □ Upper R 0 □ □ □

*4 □ □ □ □ □ Extremity L 0 □ □ □

*5 □ □ □ □ □ Lower R 0 □ □ □

*6 □ □ □ □ □ Extremity L 0 □ □ □

Signature of transcriber: ________________________ Signature of examiner: __________________________________________________

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Outpatient Osteopathic SOAP Note Form Series
Usage Guide

Introduction:

The following Outpatient Osteopathic SOAP Note Form Series was developed by the American Academy of Osteopathy's Louisa Burns Osteopathic Research Committee under a grant from the American Osteopathic Association. This valid, standardized, and easy to use form is our best recommendation to the Osteopathic Profession for research and training in osteopathic medicine.

Instructions for use:

Print where stated. All printing or writing must be legible to anyone, otherwise the record is useless. Blacken the appropriate rectangles. All bold boxed areas are critical to research data and should be filled in. Data can be collected and analyzed by a computer. Additions to the form can be made. If data were not obtained for a certain section, leave it blank or fill in the “not done” rectangle. All definitions were obtained from the CPT book and the Glossary of Osteopathic Terminology. The headings are presented and arranged as they appear on the form, beginning with the upper left-hand corner and reading to the right and down. Bold text in this Usage Guide corresponds to Form text.

Section I: Identification and Disposition

Patient's Name: Write in the patient's first and last name.

Date: Write in the date this initial summary was started. Use the following format for all dates: month/day/year.

Update: Write in the dates that this form is updated. Separate dates by comma’s, with the most recent date furthest to the right (month/day/year).

Date of Birth: (month/day/year).

Sex: Male or Female gender.

Phone Numbers: Provide Home phone number and a Work phone number, if appropriate.

Marital Status: Circle the correct letter to indicate if Married, Single, Divorced, or Widowed.

Significant Others: List them and include living arrangements.

DNR Status or Resuscitate? (Yes, No) and Qualifications: Indicate the patient's or guardian’s wishes regarding resuscitation by checking the “Yes” or “No” box. Additional desires or wishes for terminal care can be added here in the Qualifications box.

Religion: Write in the patient’s religion or preference for last rites.

Next of Kin: Write in the name of whom should be contacted in case of emergency, should the patient die, or who is the beneficiary.

Section II: Social and Family History

Social History is an age-appropriate review of past and current activities that includes significant information about:

Employment: Write in the patient's current and past employment, and, if appropriate, places of work. Indicate if patient is retired; indicate any
risk factors associated with the work place, i.e., black lung, asbestos exposure, fumes, etc.

**Occupation:** Write in the patient's areas of training (chemist, teacher, homemaker).

**Education:** Write in the patient's current school status, degrees obtained, or highest grade obtained.

**Tobacco:** Write in pack/years, what form (cigarettes, cigars, chewing tobacco), and quit-dates, if appropriate.

**ETOH (alcohol):** Write in the patient’s alcohol use in numbers, what consumed (beer, cocktails), how often (daily, weekly, monthly, yearly). Indicate past abuse and sober date.

**Drugs:** Write in the patient's illicit drug use, past and present, what, when, and for how long.

**Sex Hx (sexual history):** Write in the patient’s sexual preference, partners, menstrual history, gravida number, and para number. (The female patient has a gravida number if presently pregnant; otherwise she only has a para number. A para number is a 4-digit number indicating the number of “pregnancies-prematures-abortions-living children.”)

**Family History** is a review of medical events in the patient's family that include significant information about: (Mother, Father) the health status or cause of death of parents, Siblings, and children; specific diseases related to problems identified in the Chief Complaint or History of the Present Illness and/or System Review; diseases of family members which may be hereditary or place the patient at risk.

Use ↑ if the immediate relative (mother, father, sibling, etc.) is living and ↓ if deceased. If deceased, indicate the age of death and cause. List their pertinent health problems or history.

**Others:** List any pertinent health history or information on other relatives, such as maternal grandmother ↓ age 50, breast cancer, etc.

**Section III: Past Medical History**

**Past Medical History** is a review of the patient’s past experiences with illness, injuries, and treatment that includes significant information about:

**CPT #:** Write in any CPT codes that might be helpful for easy reference when coding.

**Start Date of Problem:** Write in the date when a problem began or when a diagnosis was first made (month/day/year).

**Problem / Diagnosis:** Write in the patient’s prior illnesses, injuries, and prior hospitalizations, in order of occurrence when possible.

**Medications:** Medications and dosages are listed in order of their initial use. Also list here over-the-counter substances, such as herbs, vitamins, and homeopathic remedies.

**Start Date for Medications:** Write in the date that each medication/substance was started and when dosages are/were changed (month/day/year).

**Stop Date for Medications:** Write in the date that each medication/substance was discontinued (month/day/year). Leave blank if the patient currently is taking a medication.

**Allergies, Adverse Drug Reactions:** List medications, foods, animals, etc., that cause allergic reactions or that produced unexpected results. List the nature of the reaction or result.

**Section IV: Health Maintenance**

**Parameter and Dates:** This is a running list of dates (month/day/year) of the usual immunizations, exams, tests and procedures. There is also a line for “Others” write-ins.

**Section V: Past Surgical History**

**Date and Type:** Surgical dates and types are listed in the order of occurrence (month/day/year).

**Section VI: Consultants**

**Consultants** are listed, including the consultant's name and specialty.
Outpatient Osteopathic SOAP Note History Form

This page of the system provides the subjective portion of a SOAP note for an outpatient patient visit.

S: The Subjective section of the SOAP note.

Section I: Patient’s Name, Date, Age, Patient’s Pain Analog Scale, and CC

Patient’s Name, Date, and Age: The first and last name of the patient and the date of this visit are recorded (month/day/year). Write in the patient’s age in years. If a child, use days up to 1 month, use months up to 1 year, and years of age.

The boxes marked Office of: and For office use only: can be used for tracking a research study, for office record keeping, etc.

Patient’s Pain Analog Scale: The patient is asked to place a mark on the 0-10 analog scale indicating the degree of pain he/she has at the time of this interview. Patients are given the following instructions: “If you have NO PAIN, place a mark at the far left side. If this is the WORST POSSIBLE PAIN you have ever experienced, indicate it at the far right side. Indicate where your pain is at this time.” If the patient doesn’t have pain or this information was not obtained, fill in the “Not done” rectangle.

CC Stands for Chief Complaint, which is a concise statement describing the symptoms, problem, condition, diagnosis or other factors that is the reason for the encounter. CC usually is stated in the patient's words. Extra lines are included here for other details of the subjective history not included in the rest of this section or those needing more space for details.

Section II. History of Present Illness, Review of Systems, and Past Medical, Family and Social History

History of Present Illness (HPI): The HPI is a chronological description of the development of the patient's present illness, from the first sign and/or symptom to the present. This includes a description of location, quality, severity, duration, timing, context, modifying factors, and associated signs and symptoms significantly related to the presenting problem(s). Fill in all rectangles and write in the details after each element listed for the history elicited. OR, write in the status of 3 or more chronic or inactive conditions on the lines provided.

Level: HPI: This is a guide for criteria needed to justify your evaluation and management CPT code in the subjective section. Fill in the rectangle that applies. The Roman numerals stand for the level of the established outpatient visit for which the patient qualifies. A level two (99212) or three (99213) code requires 1-3 of the HPI elements to qualify. A level four (99214) or five (99215) code requires ≥ 4 HPI elements OR the status of ≥ 3 chronic conditions.

Review of Systems (ROS) is an inventory of body systems, pertinent to the chief complaint, that are obtained through a series of questions seeking to identify signs and/or symptoms that the patient may be experiencing or has experienced. ROS is a guide for criteria needed to justify your evaluation and management CPT code in the subjective section. For the purposes of CPT, the following systems review has been identified: Constitutional symptoms, Eyes, Ears/Nose/Mouth/Throat, Cardiovascular, Respiratory, Gastrointestinal, Genitourinary, Musculoskeletal, Integumentary, Neurological, Psychiatric, Endocrine, Hematologic/lymphatic, and Allergic/immunologic. The review of systems helps define the problem, clarify the differential diagnoses, identify needed testing, or serves as baseline data for other systems that might be affected by any possible management options. Only fill in the rectangle(s) of those systems reviewed at this encounter. Write in any details elicited after each system. If you examine a system and it is normal, fill in the rectangle for that system and write Within Normal Limits (WNL) on that line. If no ROS information was obtained, fill in the “Not done” rectangle.

Level: ROS: The Roman numerals stand for the level of the established outpatient visit for which the patient qualifies. A level two (99212) requires no ROS. Level three (99213) requires one system pertinent to the problem. Level four (99214) requires 2-9 systems. Level five (99215)
requires listing of \( \geq 10 \) systems. Fill in the rectangle that applies.

**Past Medical, Family, Social History (PFSH):**

Past history / trauma is a review of the patient's past experiences with illnesses, injuries, and treatments that includes significant information about: prior major illnesses and injuries, prior operations, prior hospitalizations, allergies, age-appropriate immunization status, and age-appropriate feeding/dietary status.

**Allergies,** including Adverse Drug Reactions:
List medications, food, animals, etc., that cause allergic reactions or produce unexpected results. List the reaction or the result.

**Medications:** Medications and dosages are listed here. Include over-the-counter substances, such as herbs, vitamins, and homeopathic remedies.

**Family history** is a review of medical events in the patient's family that include significant information about: the health status or cause of death of parents, siblings, and children; specific diseases related to problems identified in the Chief Complaint or History of the Present Illness, and/or Systems Review; diseases of family that may be hereditary or place the patient at risk.

**Social history** is an age-appropriate review of past and current activities that includes significant information about: marital status and/or living arrangements; current employment; occupational history; use of drugs, alcohol, and tobacco; level of education; sexual history; other relevant social factors.

Fill in the rectangle(s) and write in any extra history not included on the Outpatient Health Summary Form, such as trauma history. If no medical, family or social history was obtained on the Outpatient Health Summary or the Outpatient Osteopathic SOAP Note History Form, fill in the "Not done" rectangle.

**Level: PFSH:** The Roman numerals stand for the level of the established outpatient visit for which the patient qualifies. A level two (99212) and three (99213) requires that no history areas be present. Level four (99214) requires 1 history area. Level five (99215) requires 2 or more history areas. Fill in the rectangle that applies.

**Overall History:** Fill in the rectangle that indicates the average level determined using the level of HPI, ROS or PFSH provided.

**Signature of examiner:** Signature of the attending physician is mandatory. Also, the transcriber should sign, if this is appropriate.

---

**Page 2 of 3:**

**Outpatient Osteopathic SOAP Note Exam Form**

This page of the system provides space for recording vital signs and any visceral and musculoskeletal examination findings obtained during your outpatient exam of a patient.

**O:** The Objective section of the SOAP Note.

**Section I: Patient’s Name, Date, Sex and Vital Signs**

**Not done:** If none of the objective portion was performed, fill in the Not done rectangle.

**Patient's Name:** Write in the patient's first and last name.

**Date:** Write in the date of the patient's visit (month/day/year).

**Sex:** Fill in the correct rectangle for Male or Female gender.

**Vital Signs:** Write in the corresponding vital signs on the lines provided. Three (3) of the seven (7) listed are needed to fulfill the requirements for a comprehensive examination. The seven include: 1. Wt. (weight in pounds, lbs), 2. Ht. (height in feet and inches, ft, in), 3. Temp. (temperature in degrees Fahrenheit), 4. Resp. (rate of respiration in breaths-per-minute), 5. Pulse rate (in beats per minute) and whether it is regular (Reg.) or irregular (Irreg.), 6. BP (blood pressure) Standing, Sitting, and 7. Lying down. If a measurement was not taken, leave the space blank.

The boxes marked Office of: and For office use only: can be used to identify research studies, for office record keeping, etc.
Section II: Objective Section (continued as blank lines).

Physical exam findings for any areas/systems of the General Multi-System Examination (GMS) are recorded in this section. These include: Constitutional, Eyes, Ears/Nose/Mouth/Throat, Neck, Cardiovascular, Respiratory, Chest (Breasts), Gastrointestinal (Abdomen), Genitourinary, Lymphatic, Musculoskeletal, Skin, Neurologic, and Psychiatric. The table that follows provides a section where specific musculoskeletal exam findings can be recorded and documented. Gait and station as well as inspection and/or palpation of digits and nails for the musculoskeletal exam can be put into this section to fulfill all elements of the exam that aren’t included in the somatic dysfunction table. Overflow data from the musculoskeletal exam can also be put here. Note: If no physical exam was done at this encounter, fill in the Not done rectangle at the top of Section I.

Section III: Horizontal Planes and Level of GMS

Horizontal Planes (Diagram): The diagram can be used to indicate levelness of landmarks, such as mastoid processes, shoulders, inferior angle of the scapula, iliac crests, and the superior border of the greater trochanters. (This same diagram can also be used to denote such things as lateral curvatures, the AP weight bearing line, or any other documentation that may be helpful.)

Level of GMS (General Multi-System): This is a guide for criteria needed to justify your evaluation and management CPT code in the Objective section. See the CPT book for details and definitions of elements. Fill in the rectangle that represents the level that applies.

**II 1-5 elements:** For a level two (99212) visit you must have examined one to five elements identified by a bullet.

**III 6+ elements:** For a level three (99213) visit you must have examined at least six elements identified by a bullet.

**IV 2+ from each of 6 areas OR 12+ elements in 2+ areas:** For a level four (99214) visit you must have done an examination of at least two elements identified by a bullet from each of six areas/systems OR at least twelve elements identified by a bullet in two or more areas/systems.

**V Perform all elements ≥ 9 areas.** For a level five (99215) visit, you must perform all elements identified by a bullet in at least nine organ systems or body areas and document at least two elements identified by a bullet from each of nine areas/systems.

Be advised that for the Musculoskeletal Exam, the six areas are: (1) head, face, and neck; (2) spine, ribs, and pelvis; (3) right upper extremity; (4) left upper extremity; (5) right lower extremity; (6) left lower extremity.

Warning: For a comprehensive level of exam, all four of the elements identified in TART must be performed and documented for each of four of the six anatomic areas. For the three lower levels of examination, each element is counted separately for each body area. For example, assessing range-of-motion in two extremities constitutes two elements.

Section IV: Musculoskeletal Table

Methods Used for Examination: Be sure to blacken in the rectangles indicating the tools used for your examination (T, A, R, T). Included in the definition of these components are the criteria required for coding in each body area.

- **All:** Indicates that all TART criteria were used to examine a region.
- **T:** Tissue Texture Change, stability, laxity, effusions, tone.
- **A:** Asymmetry, misalignment, crepitation, defects, masses.
- **R:** Range-of-Motion, contracture.
- **T:** Tenderness, pain.

Filling in these squares is a shortcut to a full narrative documentation in the Somatic Dysfunction and Other Systems section of this table.

Region Evaluated: This is a list of musculoskeletal body regions arranged in order based on the CPT examination documentation requirements. They include: *1. Head and Face,* and Neck; *2. The spine (Thoracic, Ribs, Lumbar, Sacrum/Pelvis, Pelvis/Innom., and Abd./Other); *3. Right Upper Extremity; *4. Left Upper Extremity; *5. Right Lower Extremity; and *6. Left Lower Extremity.* The
thoracic region is broken down into three parts based on vertebral levels for innervation specificity: T1-4, T5-9, and T10-12. This provides for ease in listing interrelationships between musculoskeletal findings and possible involvement of the visceral system.

Severity: This section refers to the severity [None (0), mild (1), moderate (2), severe (3)] of the most affected somatic dysfunction in a region. Fill in one rectangle for each region examined. For regions that are not examined, leave the rectangle empty.

If a rectangle is not marked in a region, it is assumed that that region was not examined. For regions that are examined, the scale is as follows:

- 0 None: No somatic dysfunction present or background (BG) level.
- 1 Mild: More than background, minor TART elements.
- 2 Moderate: Obvious TART; in particular Range-of-motion (R) and/or Tissue texture change (T) may or may not be overtly symptomatic.
- 3 Severe: Key lesions observed, significant, symptomatic, stands out; R and/or T elements stand out with minimum search or provocation.

(At the top of the table is a Key to the Severity Scale, which provides for a quick review.)

Somatic Dysfunction & Other Systems: Somatic Dysfunction is defined as impaired or altered function of related components of the somatic (body framework) system: skeletal, arthrodial, and myofascial structure, and related vascular, lymphatic, and neural elements. In this section for each region assessed, write your somatic dysfunctions, including musculoskeletal (MS), sympathetic nervous system (SNS), parasympathetic nervous system (PNS), lymphatic (LYM), cardiovascular (CV), respiratory (RESP), gastrointestinal (GI), fascial (FAS), etc., components. Use standard terminology.

If you filled in rectangles under TART you do not need to write anything here for coding purposes; however, this section is useful for recording notes for personal use.

Signature of examiner: Signature of the attending physician is mandatory. Also, the transcriber should sign, if this is appropriate.

### Page 3 of 3:

**Outpatient Osteopathic Assessment and Plan Form**

This page of the system is to be used with the Outpatient Osteopathic SOAP Note History and Exam Forms. It contains the Assessment and Plan for completion of a SOAP note. It provides for the Written Diagnosis, Physician’s evaluation of patient prior to treatment, treatment table for OMT, other instructions and treatments given, coding, instructions, Minutes spent with the patient, Follow-up, Units, OMT performed, Other Procedures Performed, and E/M Code.

A: The Assessment section for the SOAP note. This includes patient’s name, date, diagnosis and physician’s evaluation of patient prior to treatment.

**Section I: Patient’s Name and Date**

Patient's Name: Write in the patient's first and last name.

Date: Write in the date of the patient's visit (month/day/year).

The boxes marked Office of: and For office use only: can be used for tracking a research study, for office record keeping, etc.

**Section II: Diagnosis and Evaluation Prior to Treatment:**

Dx No. (diagnosis number): Write in your priority numbers in the Dx No. column, with “1” being the number of the patient’s most severe or addressed diagnosis at this visit.
ICD Code: Write in this column the ICD code that corresponds to your diagnosis, if it has not already been written in.

Written Diagnosis: Write on this line the description for each of your ICD codes, if not already listed.

Physician’s Evaluation of Patient Prior to Treatment: This is the physician's overall opinion of how well the patient is doing based on objective findings of the patient prior to treatment as compared to the previous visit(s):

First visit: If this is the patient’s first visit for a particular problem, mark the square after First visit.

Resolved: If the problem for which a follow-up visit was requested is resolved, mark the square after Resolved. Example: If a patient presents for a follow-up on a musculoskeletal problem, filling in the Resolved rectangle implies that the region of the previous somatic dysfunction was evaluated, with no abnormal findings being found, and that you also filled in the 0 (zero) rectangle in the severity column for that region in the Musculoskeletal Table (found on page 2 of 3).

Improved: If the problem for which a follow-up visit is improved, but not totally resolved, mark the rectangle after Improved.

Unchanged: If the problem for which a follow-up visit was requested is no different or completely unchanged from the prior visit, mark the Unchanged rectangle. This implies that, for a musculoskeletal problem, the general severity of the overall somatic findings is similar to that at the last visit. This may also apply if you evaluate or consult on a patient at one visit but do not institute any treatment at that visit.

Worse: If the problem for which a follow-up visit was requested is worse than it was at the last visit, mark the rectangle after Worse. This could occur with a musculoskeletal problem if no treatment was started at the prior visit, the patient did something to aggravate their condition, or the patient had a complication or side effect of treatment given at the last visit. This refers to the patient's condition at the current visit. This does not reflect whether the patient had an early delayed response, i.e., a flare-up from the last treatment. Flare-up information can be charted in the Subjective section of these forms (found on page 1 of 3).

Section III: Plan: Region, OMT, Treatment Method and Response

P: The Plan Section of the SOAP form. This includes a treatment table for Osteopathic Manipulative treatment. Following the table, it also records Meds (medications), Exercise, Nutritional advice, and PT (physical therapy) instructions. Other provides space for any additional advice or type of treatment you institute. Also included in this section are areas for coding, Minutes spent with patient, Follow-Up, OMT performed, Other Procedures Performed, and E/M Code.

Region lists musculoskeletal body regions arranged in order based upon CPT categories. They include Head and Face, Neck, Thoracic, Ribs, Lumbar, Sacrum, Pelvis, Abdomen/Other (viscera falls into this category), Upper Extremities, Lower Extremities. If no regions are treated, fill in the All not done rectangle.

OMT: Fill in the Yes rectangle for each region in which an examination was performed and Osteopathic Manipulative Treatment (OMT) was given. Fill in the No rectangle if OMT was not performed on a region that was examined. Note: For each region treated, there must be rectangles for Methods Used for Examination and Severity rectangles (1, 2, or 3) filled in for that region of the body examined on the Musculoskeletal Table (found on page 2 of 3).

Treatment Method: Listed here are the abbreviations of manipulative treatment modalities, approved by the profession and included in the Glossary of Osteopathic Terminology, for treatment of the somatic dysfunctions listed previously. Fill in the rectangles that correspond to the modalities used to treat each region.

BLT: balanced ligamentous tension / ligamentous articular strain treatment.
CR: cranial treatment / osteopathy in the cranial field / cranial osteopathy.
DIR: direct treatment.
FPR: facilitated positional release treatment.
HVLA: high velocity/low amplitude treatment (thrust treatment).
IND: indirect treatment.
INR: integrated neuromuscular release.
LAS: ligamentous articular strain / balanced ligamentous tension treatment.
ME: muscle energy treatment.
ST: soft tissue treatment.
OTH: any other OMT treatments used.

Response: Fill in one of these rectangles for each region of somatic dysfunction that was treated with OMT. This is the physician’s perception of how the somatic dysfunctions in each region responded to Osteopathic Treatment immediately after treatment. The rectangles are indicated as follows:

R: The somatic dysfunction is completely resolved without evidence of it ever having been present.
I: The somatic dysfunction is Improved but not completely resolved.
U: The somatic dysfunction is Unchanged or the same after treatment as it was before treatment.
W: The somatic dysfunction is Worse or aggravated immediately after treatment.

Section IV: Other Treatment Methods Used

Meds: List in this space any medications the patient will continue or new medications that will be started. Risks, benefits, and potential side effects can be listed here.

Exercise: List in this space any exercises you wish the patient to continue or add to their treatment prescription and whether they were discussed, taught, or given as handouts.

Nutrition: List in this space any nutritional, food, or diet recommendations that you have given or will give your patient.

PT: List in this space any Physical Therapy modalities your patient currently receives, has received in the office, or that you recommend they receive or do.

Other: List in this space anything that does not fit into any of the other categories. For example, counseling could be addressed in this section. If 50% or more of your time spent with the patient was spent in counseling or educating the patient, specifically list the topics discussed, the details that were included, the handouts or educational materials given, and what referrals were made.

Section V: Coding

Complexity / Assessment / Plan (Scoring):
Only two of the following three categories (Problems, Risk, Data) are required for an established visit. Note that there are five levels and five rectangles below the list for each category. Add up the total points earned from each category. Record the total for each category by blackening the appropriate rectangle under one of the five levels. The total level for complexity is the average of the three following categories included (Problems, Risk, and Data).

Problems: Find which criteria match this visit. This could be Self-limited, Established problem—improved /stable, Established—worsening, New—no workup, or New—additional workup. Add points or number of problems that fit this patient in each category. Find the total points under one of the five levels and blacken the appropriate rectangle.

Risk: Find which criteria match this visit. This could be Minimal, Low, Moderate, or High based on presenting problems, diagnostic procedures, and management options. Find the level of risk under one of the five levels and blacken the appropriate rectangle. OMT is low risk.

Data: Find which criteria match this visit. This could be Lab, Radiology, Medicine, Discuss with performing physician, Obtain records or Hx from others, Review records, discuss with physician, or Visualization of tracing, (or) specimen.

Traditional Method—Coding by Components:
For each History, Examination, and Complexity / Assessment / Plan section, put a circle around the appropriate composite level. All three areas are required for new patient visits. Then blacken the rectangle in the Final
Level of Service that denotes the average of the three levels recorded.

Optional Method—Coding by Time:

When the majority of the Encounter (50% or greater) is counseling/coordinating, the level is determined by total time. Blacken the rectangle that indicates how much time was spent counseling: New patients (minutes)—10, 20, 30, 45, 60; Established patients (minutes)—10, 15, 25, 40. Be sure in your plan to write a brief description of topics discussed. (Also be sure to blacken the appropriate rectangle that corresponds to the total time spent with the patient—see the next paragraph.)

Section VI: Minutes spent with the patient, Follow-up, Units, OMT Performed as above (number of areas), Other Procedures Performed, and E/M Code

Minutes Spent With the Patient: Blacken the rectangle that corresponds to the amount of time you spent face-to-face with the patient and/or family during their visit (10, 15, 25, 40, 60, >60 minutes). This corresponds to the time allotments in the CPT book. Choose the rectangle that best fits your total time.

Follow-up: Blacken the rectangles that correspond to when you would like to see the patient again; you must indicate both the number and the Units. For example: for a visit in one month, blacken the rectangle above the “1” and also the rectangle above M (month). Abbreviations following the Units title are: D (days), W (week), Y (year), and PRN (as needed).

OMT performed as above: Fill in the box for the number of regions with somatic dysfunction that were treated. Note: This number should correlate with the number of YES rectangles in the OMT section of the table on page 2 of 3 marked with a 1, 2, or 3. The rectangles are defined as follows:

0 areas: You treated NO (zero) regions of somatic dysfunction with Osteopathic Manipulative Treatment.

1-2 areas: You treated one to two regions of somatic dysfunction with Osteopathic Manipulative Treatment.

3-4 areas: You treated three to four regions of somatic dysfunction with Osteopathic Manipulative Treatment.

5-6 areas: You treated five to six regions of somatic dysfunction with Osteopathic Manipulative Treatment.

7-8 areas: You treated seven to eight regions of somatic dysfunction with Osteopathic Manipulative Treatment.

9-10 areas: You treated nine to ten regions of somatic dysfunction with Osteopathic Manipulative Treatment.

Other Procedures Performed: In the spaces provided, write in the CPT Codes and written diagnosis (Written Dx) for each procedure performed, other than OMT.

E/M Code: Blacken the rectangle that corresponds to the evaluation and management code for your final level of service. For a new patient visit (New) use 99202, 99203, 99204, 99205. For an established patient visit (EST) use 99211, 99212, 99213, 99214, 99215. For a consultation visit (Consults) use 99241, 99242, 99243, 99244, 99245.

Signature of examiner: Signature of the attending physician is mandatory. Also, the transcriber should sign, if this is appropriate.

D: \ Sleszynski | SOAP Note Series Usage Form. Version 5: 091102cw.
**Outpatient Health Summary**

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<thead>
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<th>Jane Doe</th>
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<tr>
<td>Sex</td>
<td>F</td>
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<td>Phone Numbers:</td>
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<tr>
<td>Home</td>
<td>262-657-5975</td>
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<tr>
<td>Work</td>
<td>847-595-2714</td>
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<tr>
<td>Significant Others:</td>
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<td>DNR Status:</td>
<td>Resuscitate? X Yes No</td>
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<td>Qualifications:</td>
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<td>Religion:</td>
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<td>Drugs:</td>
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<td>M ↑ Hypothyroid</td>
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**Past Medical History**

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**Allergies, Adverse Drug Reactions:** PCN – rash    Cat dander, ragweed

**Health Maintenance**

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**Past Surgical History**

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<td>Consultants</td>
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Funded by a grant from the Bureau of Research. © 2002 American Academy of Osteopathy. Designed to coordinate with the Established Outpatient Osteopathic SOAP Note Form. Recommended by American Association of Colleges of Osteopathic Medicine.
Patient's Name: Jane Doe  
Date: 1/1/02  
Age: 25

HISTORY

(See Outpatient Health Summary Form for details of history)

Patient's Pain Analog Scale:  □ Not done

<table>
<thead>
<tr>
<th>Location</th>
<th>Mostly mid-epigastric and mid-back</th>
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<tbody>
<tr>
<td>Quality</td>
<td>Achy, dull</td>
</tr>
<tr>
<td>Severity</td>
<td>See above back improved after OMT</td>
</tr>
<tr>
<td>Duration</td>
<td>Started 2 days ago—stomach</td>
</tr>
<tr>
<td>Timing</td>
<td>+ flare x 1 d after OMT</td>
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<tr>
<td>Context</td>
<td>Better after eating</td>
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<tr>
<td>Modifying factors</td>
<td>Bed rest helps</td>
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<td>Assoc. Signs and Sx</td>
<td>+ weakness with ↑ discomfort</td>
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</tbody>
</table>

History of Present Illness

Level: HPI

□  Status of ≥ 3 chronic or inactive conditions
□  Blood sugars—stable

□  1-3 elements reviewed
□  ≥ 4 elements OR status of ≥ 3 chronic conditions

Review of Systems (Only ask / record those systems pertinent for this encounter.)  □ Not done

□ Constitutional (Wt loss, etc.)
□ Eyes
□ Ears, nose, mouth, throat
□ Cardiovascular  No palpitations
□ Respiratory
□ Gastrointestinal  Ø Nausea or vomiting
□ Genitourinary  No pain or burning with urination
□ Musculoskeletal
□ Integumentary (skin, breast)
□ Psychiatric
□ Neurological
□ Endocrine
□ Hematologic/lymphatic
□ Allergic/immunologic

Past Medical, Family, Social History  □ Not done

□ Past history / trauma  Ø trauma
□ Allergies:
□ Medications: Norflex 100 mg p o BID

□ Family history  ↓ F at 46 yrs of PUD
□ Social history

Overall History = Average of HPI, ROS or PFSH:

□ II (1-3 HPI)  □ III (1-3 HPI, 1 ROS)  □ IV (4+ HPI, 2-9 ROS, 1 PFSH)  □ V (4+ HPI, 10+ ROS, 2+ PFSH)

Signature of transcriber: ______________________________
Signature of examiner: SLSLESZYNSKI DO

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Designed to coordinate with the Established Outpatient Osteopathic SOAP Note Form. Recommended by American Association of Colleges of Osteopathic Medicine.
Patient's Name: Jane Doe
Date: 01/01/02
Sex: Male

* Vital Signs (3 of 7)
  Wt. __130 lb.__
  Ht. __5' 5"__
  Temp. __98.6__

Reg. __I__  Pt. position for recording BP:
Res. __20__  Pulse __80__  Irreg. __
Standing __Sitting__ __120 / 80__  Lying __

Abdomen—tender epigastrium, + bowel sounds in 4 quadrants, Ø masses.
UE—Bilateral muscle strength 5 / 5.

Signature of transcriber: ________________________ Signature of examiner: ________________

SLSlezynskiDO
**Physician’s evaluation of patient prior to treatment: First visit**

**Patient’s Name**

**Signature of transcriber: _________________________________**

**Signature of examiner:  __________**

**Write 992 plus . . .**

**E/M Code: New**

**Other Procedures**

**Performed:**

**CPT Codes:**

**OMT performed as Above:**

**0 areas**

**1-2 areas**

**3-4 areas**

**5-6 areas**

**7-8 areas**

**9-10 areas**

**OMT performed as Above:**

**0 areas**

**1-2 areas**

**3-4 areas**

**5-6 areas**

**7-8 areas**

**9-10 areas**

**CPT Codes:**

**97010**

**97110**

**Write 992 plus . . .**

**02 03 04 05 . . . 11 12 13 14 15 . . . 41 42 43 44 45**

**Signature of transcriber:**

**Signature of examiner:**

**SL Sleszynski DO**
### Outpatient Health Summary

#### Patient's Information:
- **Name:** [Blank]
- **Date of Birth:** [Blank]
- **Sex:** [Blank]
- **Marital Status:** M S D W
- **Phone Numbers:** [Blank]
- **Significant Others:** [Blank]
- **DNR Status:** [Yes/No]
- **Qualifications:** [Blank]
- **Resuscitate?** [Yes/No]
- **Religion:** [Blank]
- **Next of Kin:** [Blank]

#### Social History:
- **Employment** [Blank]
- **Occupation** [Blank]
- **Education** [Blank]
- **Tobacco** [Blank]
- **ETOH** [Blank]
- **Drugs** [Blank]
- **Sex Hx** [Blank]

#### Family History:
- **M** [Blank]
- **Siblings** [Blank]
- **F** [Blank]

#### Past Medical History:

<table>
<thead>
<tr>
<th>CPT#</th>
<th>Start Date</th>
<th>Problem / Diagnosis</th>
<th>Medications</th>
<th>Start</th>
<th>Stop</th>
</tr>
</thead>
<tbody>
<tr>
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</table>

#### Allergies, Adverse Drug Reactions:

#### Health Maintenance:

<table>
<thead>
<tr>
<th>Parameter</th>
<th>Dates</th>
<th></th>
<th>Date</th>
<th>Type</th>
</tr>
</thead>
<tbody>
<tr>
<td>DPT/DT/TD</td>
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<tr>
<td>OPV</td>
<td></td>
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<tr>
<td>MMR</td>
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</tr>
<tr>
<td>HIB</td>
<td></td>
<td></td>
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<tr>
<td>Influenza</td>
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<td></td>
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<tr>
<td>Hepatitis</td>
<td></td>
<td></td>
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<tr>
<td>PPD/Tine</td>
<td></td>
<td></td>
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<td></td>
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<tr>
<td>Pneumovax</td>
<td></td>
<td></td>
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<tr>
<td>H &amp; P</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Eye exam</td>
<td></td>
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<tr>
<td>Dental exam</td>
<td></td>
<td></td>
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<tr>
<td>PAP smear</td>
<td></td>
<td></td>
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<tr>
<td>Mammogram</td>
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<td></td>
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<tr>
<td>Urinalysis</td>
<td></td>
<td></td>
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<tr>
<td>Hemoccult</td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Cholesterol</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Sigmoidoscopy</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Others</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

#### Past Surgical History:

<table>
<thead>
<tr>
<th>Date</th>
<th>Type</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Consultants</td>
</tr>
</tbody>
</table>


## HISTORY

### S

(See Outpatient Health Summary Form for details of history)

### Patient's Pain Analog Scale:

- [ ] Not done

<table>
<thead>
<tr>
<th>NO PAIN</th>
<th>WORST POSSIBLE PAIN</th>
</tr>
</thead>
</table>

### CC

### History of Present Illness

<table>
<thead>
<tr>
<th>Elements</th>
<th>Level: HPI</th>
</tr>
</thead>
<tbody>
<tr>
<td>Location</td>
<td>II (1-3 HPI)</td>
</tr>
<tr>
<td>Quality</td>
<td>III (1-3 HPI, 1 ROS)</td>
</tr>
<tr>
<td>Severity</td>
<td>IV (≥ 4 elements OR status of ≥ 3 chronic conditions)</td>
</tr>
<tr>
<td>Duration</td>
<td>V (≥ 4 elements OR status of ≥ 3 chronic conditions)</td>
</tr>
<tr>
<td>Timing</td>
<td></td>
</tr>
<tr>
<td>Context</td>
<td></td>
</tr>
<tr>
<td>Modifying factors</td>
<td></td>
</tr>
<tr>
<td>Assoc. Signs and Sx</td>
<td></td>
</tr>
</tbody>
</table>

### Review of Systems (Only ask / record those systems pertinent for this encounter.)

- [ ] Not done

<table>
<thead>
<tr>
<th>Level: ROS</th>
</tr>
</thead>
<tbody>
<tr>
<td>II None</td>
</tr>
<tr>
<td>III 1 system pertinent to the problem</td>
</tr>
<tr>
<td>IV 2-9 systems</td>
</tr>
<tr>
<td>V ≥ 10 systems</td>
</tr>
</tbody>
</table>

### Past Medical, Family, Social History

- [ ] Not done

<table>
<thead>
<tr>
<th>Level: PFSH</th>
</tr>
</thead>
<tbody>
<tr>
<td>II None</td>
</tr>
<tr>
<td>III None</td>
</tr>
<tr>
<td>IV 1 history area</td>
</tr>
<tr>
<td>V ≥ 2 history areas</td>
</tr>
</tbody>
</table>

### Overall History = Average of HPI, ROS or PFSH:

- [ ] II (1-3 HPI) |
- [ ] III (1-3 HPI, 1 ROS) |
- [ ] IV (≥ 4 elements OR status of ≥ 3 chronic conditions) |
- [ ] V (≥ 4 elements OR status of ≥ 3 chronic conditions) |
Outpatient Osteopathic SOAP Note Exam Form

Patient’s Name _______________________

Date ________ Sex: Male ☐ Female ☐

Vital Signs (3 of 7) Wt. ____________ Ht. ______________ Temp. ____________

Reg. ☐ Irreg. ☐ Pt. position for recording BP:

Resp. ____ Pulse ____

Level of GMS

☐ II 1-5 elements
☐ III 6+ elements
☐ IV 2+ from each or 6 areas OR 12+ elements in 2+ areas
☐ V Perform all elements ≥ 9 areas

Methods Used For Examination

<table>
<thead>
<tr>
<th>Region</th>
<th>Severity Scale</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>0 = No SD or background (BG) levels</td>
</tr>
<tr>
<td></td>
<td>1 = More than BG levels, minor TART</td>
</tr>
<tr>
<td></td>
<td>2 = Obvious TART (esp. R and T), +/- symptoms</td>
</tr>
<tr>
<td></td>
<td>3 = Key lesions, symptomatic, R and T stand out</td>
</tr>
</tbody>
</table>

Key to the Severity Scale

<table>
<thead>
<tr>
<th>Region</th>
<th>Severity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Head and Face</td>
<td></td>
</tr>
<tr>
<td>Neck</td>
<td></td>
</tr>
<tr>
<td>Thoracic T1-4</td>
<td></td>
</tr>
<tr>
<td>Thoracic T5-9</td>
<td></td>
</tr>
<tr>
<td>Thoracic T10-12</td>
<td></td>
</tr>
<tr>
<td>Ribs</td>
<td></td>
</tr>
<tr>
<td>Lumbar</td>
<td></td>
</tr>
<tr>
<td>Sacrum / Pelvis</td>
<td></td>
</tr>
<tr>
<td>Pelvis / Innom.</td>
<td></td>
</tr>
<tr>
<td>Abd / Other</td>
<td></td>
</tr>
<tr>
<td>Upper R</td>
<td></td>
</tr>
<tr>
<td>Extremity L</td>
<td></td>
</tr>
<tr>
<td>Lower R</td>
<td></td>
</tr>
<tr>
<td>Extremity L</td>
<td></td>
</tr>
</tbody>
</table>

Signature of transcriber: ________________________ Signature of examiner: __________________________________________________

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### Outpatient Osteopathic Assessment and Plan Form

**Physician's evaluation of patient prior to treatment:** First visit  
Resolved  
Improved  
Unchanged  
Worse  

---

**Patient's Name**

**A**  

**Physician**

**Dx No.**  **ICD Code**  **Written Diagnosis**  **Dx No.**  **ICD Code**  **Written Diagnosis**

- 739.0 Somatic Dysfunction of Head and Face
- 739.1 Somatic Dysfunction of Neck
- 739.2 Somatic Dysfunction of Thoracic
- 739.3 Somatic Dysfunction of Lumbar
- 739.4 Somatic Dysfunction of Sacrum
- 739.5 Somatic Dysfunction of Pelvis
- 739.7 Somatic Dysfunction of Upper Extremity
- 739.9 Somatic Dysfunction of Abd / Other
- 739.8 Somatic Dysfunction of Ribs
- 739.6 Somatic Dysfunction of Lower Extremity

---

**Treatment Method**  
- Staff editing
- Estimated—seeing
- New—or workup
- New—even additional workup

**Response**  
- Level I
- Level II
- Level III
- Level IV
- Level V

**Nutrition:**

**Complexity / Assessment / Plan (Scoring)**  
*Default to level 2—same criteria*

**Problems**  
- Level I
- Level II
- Level III
- Level IV
- Level V

**Risk (presenting problem(s), diagnostic procedure(s), management options)**  
- Lab
- Radiology
- Medicine
- Other

**Data**  
- Minimum
- Moderate
- High

**Maximum Points**  
- Low
- Mod.
- High

**Units:**

- Office of:
- For office use only:

---

**OMT performed as Above:**

**Other Procedures Performed:**

**CPT Codes:**

**Written Dx:**

**E/M Code:**  
- New

**Follow-up:**

**Units:**

- 02 03 04 05 06 07 08 09 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 33 34 35 36 37 38 39 40 41 42 43 44 45

---

**Signature of transcriber:**

**Signature of Examiner:**

---

#### Outpatient Osteopathic SOAP Note Form

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