Standardized medical record: A new Outpatient Osteopathic SOAP Note Form: Validation of a standardized office form against physician's progress notes

SANDRA L. SLESZYNSKI, DO
THOMAS GLONEK, PhD
WILLIAM A. KUCHERA, DO, FAAO

The accuracy and efficiency of recording information on a one-page standardized Outpatient Osteopathic SOAP Note Form (SNF) was compared with that obtained using the physician's progress notes (PPN). Use of the SNF in lieu of the PPN would assure the physician that proper clinical data were recorded to ensure proof of need and care in any instances of refused reimbursement. Moreover, standardized SNFs could be used to document and analyze present treatment protocols, enabling medical advances. Ten osteopathic physicians, who were skilled in osteopathic manipulative treatment (OMT), enrolled 300 patients. Initial and follow-up examinations totaled 959 visits (statistical cases); 76 statistical variables were compared. Essentially all information recorded in the PPN was recorded on the SNF. A significant difference ($P < .05$) was found between the PPN data set and the SNF data set in all but 17 of the 76 variables. Greater content of information almost always was found with the SNF data set. In addition, the SNF contained information not found in the PPN, most notably the severity and response to treatment of detected somatic dysfunctions. Participating physicians stated that the SNF takes about the same amount of time to fill in as the PPN. This makes the SNF a practical instrument for accurately and efficiently obtaining patient data in all physicians' offices. The validation study conducted demonstrated that the Outpatient Osteopathic SOAP Note Form easily and accurately reflected information recorded in the PPN and that data recorded may be used by physicians in their individual practices or for the conduct of osteopathic research.

(Key words: Billing guide, data collection, documentation, medical record keeping, osteopathic manipulative charting, outpatient note recording, progress notes, research forms, SOAP format, standardized medical record)

Dr Sleszynski is an affiliate clinical assistant professor for Chicago College of Osteopathic Medicine, board eligible for the American Osteopathic Board of Neuromusculoskeletal medicine and OMT, and solo private practitioner at Crossroads Premiere Health Care, SC, Kenosha, Wis; Dr Glonek is an associate professor, physiology and research professor, osteopathic manipulative medicine at the Osteopathic Manipulative Medicine Department, Chicago College of Osteopathic Medicine, Midwestern University, Down-

ers Grove, Ill; and Dr Kuchera is Emeritus Professor, Kirksville College of Osteopathic Medicine, Kirksville, Mo.

This development of an Outcomes Research SOAP Note form is a project under the auspices of the Louisa Burns Osteopathic Research Committee and is funded by the American Osteopathic Association Bureau of Research.

Correspondence to Sandra L. Sleszynski, DO, Crossroads Premiere Health Care, SC, 1010 35th St, Kenosha, WI 53140.

There have been numerous clinical reports regarding the effectiveness of osteopathic palpatory evaluation and manipulative treatment in the management of a variety of diseases and other disorders of structure and function. If the profession is to meet and excel in the increasingly competitive arena of healthcare provision, it must provide information on those disorders that are central in its treatment management.

One of the persistent problems that has faced the profession is the lack of an easy-to-use, reliable, and consistent method for recording the findings of a musculoskeletal examination. For this reason, the profession lacks years of data that could have been reliably and statistically used to correlate the findings of somatic dysfunction with the effects of osteopathic manipulative treatment (OMT).

We must gather statistics to show how the unique disorders that our profession treats are distributed in the population. There have been attempts to present a standardized format for such examinations.¹ Various forms also have discussed standardization for research protocols.² Most of these forms provided complete guides to the documentation of osteopathic palpatory diagnosis and somatic dysfunctions, but they were generally too cumbersome to be used for outcomes research involving large groups of participating physicians.

With the growing call for outcomes-based research in the osteopathic medical profession,^{3,4} there exists a need for a standardized recording format. This format must efficiently serve the needs of practicing physicians yet provide the ability to create a database for the collection of vital statistical information. The data must include the prevalence, frequency, and severity of somatic dysfunctions diagnosed in various classes of patients and the effects that treatment of these observed somatic dysfunctions have on the prognosis of these patients.

The Louisa Burns Osteopathic Research Committee of the American Academy of Osteopathy set about to develop and validate an outcomes instrument for documenting objective change

resulting from the treatment of somatic dysfunctions found in patients treated in a typical osteopathic physician's office. We call this tool the Outpatient Osteopathic SOAP Note Form (SNF) (*Figure.*) A guide to the use of this tool also has been developed and is included in the Appendix. The "Usage Guide" defines osteopathic medical terms used and will answer questions one might have when reading the research write-up. We hypothesized that our Outpatient Osteopathic SNF would accurately record pertinent information about somatic dysfunction which is typically recorded in the physician's progress note (PPN). Although the form initially looks complicated, the abbreviations are standard, and because a physician's practice maintains a certain consistency in types and forms of treatment used, once the form becomes familiar in a short learning phase, recording becomes rapid. Physician compliance, performance over time, and difficulties and obstacles encountered while using the form were determined in this study.

It is anticipated that use of the SNF will be embodied into a "vertically integrated seamless osteopathic curriculum." This form has already been introduced at the medical school level and is in the process of being incorporated into the current recommendations for research programs of osteopathic post-doctoral training institutes (OPTIs). The form is presently available from the American Academy of Osteopathy for use by physicians in their offices or physician groups at state, regional, or national levels.

Medical record data recorded in PPN were compared with recording on the SNF. Content was evaluated to determine whether the SNF was an adequate recording instrument that could be used in lieu of PPN. Use of such a validated instrument not only assures the physician of having a complete record of care on each patient's visit, but also, if the physician wishes, provides for the efficient collection of large amounts of readily usable patient data for private or professional analysis, without extending the physician's recording time.

Materials and methods

Data were collected over 2 months. Ten participating physicians (5 osteopathic manipulation specialists and 5 nonspecialist osteopathic physicians) were chosen from various backgrounds—4 physicians from teaching institutions, 4 private practice physicians, and 2 physicians in group practices. A training session on the use of the SNF was conducted at the start of the study; 6 of the 10 physicians were able to attend the training session. Those that could not attend were given written information and a phone number to call if questions arose regarding the use of the SNF. Questions involving idiosyncrasies of any specific physician's practice were answered. Before leaving the training session, each physician was required to fill out an SNF correctly on one subject (a fellow trainee).

This study was limited to the medical practice and record keeping in private physicians' offices. No patient names or identifying information was used. No specific treatment procedures or changes in any physician's existing pattern of patient care were involved. Thus, there was no need for consent forms or Institutional Review Board approval.

The physicians collected and documented patient information in the format that they were accustomed to using and then immediately, or at least within 24 hours after the PPN was recorded, they completed the trial SNF. Patients in the practice of each physician were entered into the study in a sequential manner regardless of their complaints. A minimum of 30 patients was entered into the study from each practice setting. This enrollment allowed testing of the form for all types of patient problems, not just those of a musculoskeletal nature. This diversity was essential to the study, as the form is intended for use by all primary care and specialist physicians within the profession. For those patients who had a follow-up appointment within the 2 months after their initial study visit, a second SNF was completed. If a patient was seen more than once for follow-up within the 2 months, only the first follow-up encounter was recorded and submitted.

The patients' names were removed from a copy of the PPN and an identification (ID) number was put in its place. The same ID number was placed on the trial SNF. This procedure maintained patient confidentiality. Only each physician kept a list of his or her patients' names and their numbers to permit proper coding of follow-up visits. At the completion of the initial intake of patients and again at the end of the study, copies of all the PPNs and the trial outcomes SNFs were sent to the Center for Osteopathic Research and Educational Development at Midwestern University, Chicago. It was there that data entry and subsequent statistical analysis were performed, using their statistical system.⁵

At the data collection center, a trained data entry technician, a statistician, and several consultant osteopathic physicians transcribed the information from the original PPN onto a second (color-coded) SNF so that data could be easily compared and rendered amenable to computerized processing. This first step in the process of analysis was laborious and required several months to complete; nevertheless, the SNF format used was a successful recording instrument, as all PPN entries could be accommodated.

The second task was to define and enter a set of variables that defined control factors as well as the data for entry into the *Statistical Package for the Social Sciences*, 6th edition, (SPSS6) statistical spread sheet that addressed the question: How did entries vary (differ) between the PPN and the SNF? In addition, correlations between the five-point severity scales and the response to OMT were computed. To reduce the incidence of errors during data entry, the bulk of the data was entered as string variables, using a logical code that required little or no interpretation on the part of the data-entry technician. For example, data were simply present or absent and entered as "P" (present) or "A" (absent). "Present/absent" data have no missing values (that is, when nothing was listed, it was treated as "absent"). Yes/no responses were entered as "Y" (yes) and "N" (no). "Yes/no" data usually have "missing values." Ordinal strings usually were entered

Outpatient Osteopathic SOAP Note Form

Office of: _____

Patient's Name: _____

Sex: ☐ Male ☐ Female ☐

For office use only: _____

Date: _____

Age: _____

Vital Signs: B/P _____

Pulse _____

Respir. _____

Temp. _____

Wt. _____

Ht. _____

S

CC: _____

HPI: _____

ROS/PFSH: _____

Meds: _____

O

Level: _____
2 1-3 HPI
3 1-3 HPI, 1 ROS
4 4+ HPI, 2-9 ROS,
1 PFSH
5 4+ HPI, 10+ ROS,
2+ PFSH

Level of GMS _____
2 • 1-5 elements
3 • 6+ elements
4 • 2+ from each
of 6 areas
or 12+ elements in
2+ areas
5 • 2+ elements from
each of 9 areas

Methods Used to Examine: T ☐ A ☐ R ☐ passive active ☐ T ☐ Severity Scale: 1 No SD or background (BG) levels 2 Obvious TART (esp. R and T), +/- symptoms 3 More than BG levels, minor TART 4 Key lesions, symptomatic, R and T stands out

Region Evaluated	Severity				Somatic Dysfunctions and Other Systems MS / SNS / PNS / LYM / CV / RESP. / GI / FAS. / etc.	OMT		Treatment Method (Circle Treatment Methods Used)	Response			
	0	1	2	3		Yes	No		R	I	U	W
Head	☐	☐	☐	☐		☐	☐	ART / BLT / CR / CS / DIR / FPR / HVLA IND / INR / LAS / ME / MFR / ST / VIS	☐	☐	☐	☐
Cervical	☐	☐	☐	☐		☐	☐	ART / BLT / CR / CS / DIR / FPR / HVLA IND / INR / LAS / ME / MFR / ST / VIS	☐	☐	☐	☐
Thoracic T1-4	☐	☐	☐	☐		☐	☐	ART / BLT / CR / CS / DIR / FPR / HVLA IND / INR / LAS / ME / MFR / ST / VIS	☐	☐	☐	☐
T5-9	☐	☐	☐	☐		☐	☐	ART / BLT / CR / CS / DIR / FPR / HVLA IND / INR / LAS / ME / MFR / ST / VIS	☐	☐	☐	☐
T10-12	☐	☐	☐	☐		☐	☐	ART / BLT / CR / CS / DIR / FPR / HVLA IND / INR / LAS / ME / MFR / ST / VIS	☐	☐	☐	☐
Lumbar	☐	☐	☐	☐		☐	☐	ART / BLT / CR / CS / DIR / FPR / HVLA IND / INR / LAS / ME / MFR / ST / VIS	☐	☐	☐	☐
Sacrum/Pelvis	☐	☐	☐	☐		☐	☐	ART / BLT / CR / CS / DIR / FPR / HVLA IND / INR / LAS / ME / MFR / ST / VIS	☐	☐	☐	☐
Pelvis/Innom.	☐	☐	☐	☐		☐	☐	ART / BLT / CR / CS / DIR / FPR / HVLA IND / INR / LAS / ME / MFR / ST / VIS	☐	☐	☐	☐
Extremity lower	☐	☐	☐	☐		☐	☐	ART / BLT / CR / CS / DIR / FPR / HVLA IND / INR / LAS / ME / MFR / ST / VIS	☐	☐	☐	☐
Extremity upper	☐	☐	☐	☐		☐	☐	ART / BLT / CR / CS / DIR / FPR / HVLA IND / INR / LAS / ME / MFR / ST / VIS	☐	☐	☐	☐
Ribs	☐	☐	☐	☐		☐	☐	ART / BLT / CR / CS / DIR / FPR / HVLA IND / INR / LAS / ME / MFR / ST / VIS	☐	☐	☐	☐
Abd./Other	☐	☐	☐	☐		☐	☐	ART / BLT / CR / CS / DIR / FPR / HVLA IND / INR / LAS / ME / MFR / ST / VIS	☐	☐	☐	☐

Physician's evaluation of patient prior to treatment: First Visit ☐ Resolved ☐ Improved ☐ Unchanged ☐ Worse ☐

A

1. _____ 3. _____
2. _____ 4. _____

P

OMT performed as above: 1-2 areas ☐ 3-4 areas ☐ 5-6 areas ☐ 7-8 areas ☐ 9-10 areas ☐

Meds: _____ PT: _____

Exercise: _____ Other: _____

Nutrition: _____

Minutes spent with patient: ☐ 10 ☐ 15 ☐ 25 ☐ 40 ☐ 60 ☐ >60 Follow-up: ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 8 ☐ 11 ☐ 12 Units: ☐ Days ☐ Wk. ☐ Mo. ☐ Yr. ☐ PRN

Signature of the examiner: _____

Medical Decisions:
2 Minimal decisions
3 Limited decisions
4 Moderate decisions
5 Excessive decisions
(based on # of options,
complexity of records,
risk of significant
complications.)

Figure. Outpatient Osteopathic SOAP Note Form. (Reprinted with permission of the American Academy of Osteopathy.) Copies of the Outpatient Osteopathic SOAP Note Form can be obtained from the American Academy of Osteopathy at \$5 per each original, 3500 DePauw Blvd, Suite 1080, Indianapolis, IN 46268-1136; telephone: 317-879-1881.

using an appropriate letter code, for example, "R" (resolved), "I" (improved), "U" (unchanged), and "W" (worse). In some instances, for example the head-region severity variable ("headsev"), the spreadsheet variable was defined as numeric and ordinal numerals (1 through 5) were entered. This procedure facilitated data entry, and only 9 errors were detected by verification and descriptive statistics in the set of 90,146 data cells entered (0.01% error rate).

No estimate of translation errors was available, because there was no independent verification of PPN translation by a second investigative team. Expert advice was sought when questions of translation arose. Spot-checking by osteopathic physicians not involved in the translation effort established the veracity of the translations. The investigators believe that any translation errors that are present will not significantly alter the statistical findings.

Statistical procedures involved descriptive statistics, cross-tabulation, significance of cross-tabulation by χ^2 with Pearson correlation, continuity correction, and likelihood ratio. A probability ($P < .05$) was accepted as significant. As may have been appropriate, cross-tabulations were computed with and without inclusion of the "missing values" data set, because investigator compliance in filling out the form was a pertinent issue in this analysis. Depending on the variables involved and the nature of the statistical question, either nominal or ordinal cross-tabulations were performed.

At the end of the study, 8 of the 10 physicians involved in the validation of the SNF completed a physician exit survey that asked questions regarding satisfaction, ease of use, and time efficiency. We held a follow-up meeting that included the participating physicians and some members of the Louisa Burns Osteopathic Research Committee. This meeting asked the physicians about the feasibility of using the form in practice and whether they thought that the form contained valid data on OMT process and outcomes. Benefits, drawbacks, ease of use, and other comments regarding the SNF were discussed thoroughly.

After the initial exit survey information was obtained, 8 of 10 physicians completed an additional questionnaire. This survey helped us to determine the time investment for filling out the SNF and presented us with recommendations for improvement.

Results

Statistical analysis

Cross-tabulation occurrences of the SNF and PPN information were obtained from the 959 statistical cases in this study. In all analyses, "missing values" were treated statistically as missing, that is, for the purpose of cross-tabulation and determination of significance, cases having "missing values" were *not* counted. "Missing values" are a failure to report requested data. They are important because they are a measure of physician reporting compliance. Therefore, missing values were counted in the determination of the descriptive statistics. A comparison of first and second research visits revealed no significant differences. The data from the first and second research visits therefore were combined in subsequent analyses.

Medical record data that are tested only rarely (patient demographic data, age, etc) and that may be found in other sections of the PPN were not copied for purposes of this study. These data therefore will constitute missing data insofar as the study is concerned, even though the physician has previously recorded the data and could produce such data if requested. This factor introduces a bias into the data acquisition that was anticipated.

The mean patient age was 46 years, with a range of 1 to 88 years. Age was reported 57% of the time (549 times)—41% reported on the SNF and only 16% reported on the PPN.

Analysis of variables

The analysis consisted of 81 variables compared by cross-tabulation, with some of the data ranked and ordered. Detailed tabulations of the findings, including computed probabilities, may be obtained from the American Academy of Osteopathy. The following is a summa-

ry of the findings presented in these tables.

Each of the 10 physicians produced about 10% of the cases, which were essentially equally divided between first and second patient visits. Case distribution therefore was considered equal and did not introduce the statistically confounding factor of nonequality among the statistical groups.

Nearly half of the data addressing "how the patient feels today" was missing from the PPN (missing data, 703 cases). Fewer, but still a considerable number of these data, were missing from the SNF (279 cases) as well. Whether the missing data were included in the analysis did not affect the outcome ($P < .000$). This is a curious finding having no apparent explanation.

The variable representing "chief complaint" may be considered the "ideal physician's-response variable" in the sense that its reporting was essentially equivalent between the two groups ($P < .760$). Other data items for which there was essentially equivalent reporting between experimental groups were "vital signs" ($P < .273$), "other information" ($P < .083$), and "somatic dysfunction for any one of the 10 body regions" (data from 10 body regions treated globally, $P < .173$).

Medications were written down more often in the subjective sections of the PPN than on the SNF ($P < .000$). Interview data suggested that this difference might have been a consequence of the format of the form, which was found to be confusing to some of the physicians.

Significantly more information was provided on the SNF than was provided in the PPN when considering variables addressing "severity of dysfunction," "treatment," "response to treatment," and an item for "comment" (data treated globally, $P < .000$, .054, .000, and .000, respectively).

In the matrix section of the SNF, the columns under the heading "Region Evaluated" were to have been answered with a "yes" or a "no." The investigators reported that this part of the instructions was not well understood, and answers of "no" were rarely indicated,

resulting in a considerable quantity of missing data, exceeding 50% of the information requested. This portion of the SNF has been altered, with the "yes" and "no" columns removed. (See subsequent text related to this item.). More information was reported in the SNF than in PPN ($P < .000$ for all 10 body regions).

Data between the SNF and PPN groups were equivalent (all P values $> .169$; average P for all 10 body regions $> .428$) for variables addressing the "presence of somatic dysfunction for the 10 body regions."

No severity data were reported in the PPN entries. This item therefore represents new data from the SNF. It was the Committee's consensus that the severity scale should be retained and that a "0" (zero) column be added to indicate *no* somatic dysfunction detected. This revision renders the "yes" column under "Region Evaluated" redundant, and the "yes" column was dropped in the revision.

Significantly more data were reported on the SNF than in the PPN for the columns dealing with "body regions receiving OMT," "body regions receiving other treatment," "response of these regions to OMT," and "comments" regarding treatment ($P < .000$ for all body regions except for those under "Comment"). Probabilities under "Comment" were less than .004 except for "lower extremities" ($P < .029$) and "other region assessed" ($P < .309$), where reported data were sparse.

The "Comment" column was essentially unused, and it was the consensus that the column be replaced with a column for "Treatment method," which provides information regarding the OMT modalities used to treat somatic dysfunction.

Regarding "physician assessment," there were more data present on the SNF than in the PPN; however, there were much missing data. Missing data were twice as great with the PPN than with the SNF (Table).

The variables addressing physician assessment codes and the number of times OMT was performed were equal-

ly reported on the SNF and the PPN (P nominally $> .7$).

There were significantly more data in the SNF than in the PPN for variables addressing "medications prescribed," "physical therapy prescribed," and "exercise prescribed" (for all $P < .000$).

More data were present in the PPN than in the SNF for the variable that addressed "other treatments" ($P < .000$). Finally, reporting was equivalent between the SNF and the PPN for the variable addressing "follow-up notes" ($P < .700$). Several correlations were examined. Correlations (Pearson's R and Spearman's) were computed relating the severity scale and the response to OMT. There was no correlation. Regarding the level of severity and the level of response, a qualitative assessment gleaned from the counts registered in the cross-tabulations of column pairs showed no significance between, for example, severity of 1 and severity of 5. Also, there was no correlation with response using groupings smaller than the complete severity set of 1 to 5. Our conclusion: As far as it concerns "providing improvement in a patient's condition," OMT works equally well for patients having mildly severe dysfunction as it does for those with very severe somatic dysfunction.

The question of whether the severity of a somatic dysfunction made a difference in the response obtained requires further clarification. Only the SNF data set was selected, and only cases having a positive severity response or, in a second analysis, only a positive (OMT) response were selected. (The PPN data set did not provide such information.) In this limited study, it was concluded that it is only necessary that there be a somatic dysfunction for OMT to be useful; the severity of the dysfunction is irrelevant.

Details of the foregoing results can be obtained from the American Academy of Osteopathy.

Exit survey

After all patient SNFs and PPNs were turned in, 9 of the 10 physicians filled out a 10-question exit survey of their impression of the study. Analysis of the

response to the 10 questions prompted the creation of 5 more questions to which 8 of the 10 physicians responded. From the exit interviews and the survey responses, the following information was obtained.

There were 10 patients who refused to participate in the study. The reasons for these decisions were not listed. All physicians answered "yes" to the question, "Were the instructions for use of the form clear?" The large amount of missing data, however, indicated that there seemed to be some confusion or lack of compliance regarding filling out the form in its entirety.

Fifty percent of physicians thought that the SNF helped alert them to important information that they would have omitted in their PPN. Statistical analysis confirmed these findings. There were fewer missing data in the SNF data set especially in the key areas of research that included the severity and treatment sections.

Except for an initial learning period, physicians reported that the form was easy to fill out. Each physician was asked how long it took to complete the PPN and the SNF. An average was then calculated for all answers obtained. By the end of the study, physicians said that it took an average of 4.1 minutes to fill out their PPN and an average of 4.5 minutes to fill out the SNF; this time difference was negligible. This finding is especially significant when it comes to widespread use of the SNF for physicians not involved in research.

Sixty percent of the physicians said "Yes" when asked, "Would you use the Osteopathic SOAP Note Form (SNF) in your office for general or research use?" The remainder said they "would not use it because too much time was required to fill it out." This latter response was inconsistent with the statistical finding that indicated it took an equivalent amount of time (approximately 4 minutes) to complete either method of recording.

Physicians offered suggestions as to revisions that they favored: how space should be allotted, what items should be changed, how the form could be

Table
Cross-tabulation of Physician Assessment Data

Assessment	Outpatient Osteopathic SOAP Note Form			Physician's progress notes		
	Count			Count		
	Total	By row, %	By column, %	Total	By row, %	By column, %
☐ Patient improved	179	89.9	37.6	20	10.1	4.1
☐ Problem resolved	11	84.6	2.3	2	15.4	0.4
☐ Problem unchanged	56	98.2	11.8		1.8	0.2
☐ Problem and patient worse	1	100.0	0.2			
☐ Data missing from response column	229	33.2	48.1	460	66.8	95.2

made easier to use in their practice. They offered suggestions to clarify criteria used for determining the severity of somatic dysfunction and to include specific details on how to evaluate and record in the "how the patient is feeling today" section.

The repetition required in filling out the SNF provided insight into physician compliance, and the physician exit survey provided information about time efficacy and physician satisfaction. Although participating physicians were instructed not to change their current medical record system, we recognized that it was inevitable that change occurred in physicians' practices through the mechanism of increasing each physician's awareness of important key items. In general, these changes are viewed as strengthening medical practice.

Discussion

The SNF was shown to contain detailed information not expected to be found in the PPN. Some data found on the SNF, such as patient demographic information, currently is found in other places in the patient's office chart. Of course, these details would appear as missing data in our analysis.

The SNF provides information needed for longitudinal research in tracking somatic dysfunction, its response to treatment, its effect on patients' overall health,

and its effects on prevention and control of all types of disease and dysfunction. The areas of the form containing information in boxes were deemed necessary to correctly determine these longitudinal factors and offer a uniform format for easy recognition of sought-after data important in future studies.

In addition to our analysis, the comments and suggestions from the participating physicians were essential in making changes to the form, which we then named the "Outpatient Osteopathic SOAP Note Form."⁵ Recording changes and clinical data are the next phases in outcome research. That phase will involve OMT, changes in somatic dysfunction, patient satisfaction, changes in health status and cost-effectiveness resulting from the administration of OMT in the management of all types of patients.

It was the Committee's consensus that the severity scale should be retained and that it be expanded to include a 0 (zero) column to indicate "no somatic dysfunction" detected in a region. This revision allowed elimination of a "Yes" and a "No" column indicating whether a region was assessed. After extensive discussion by the Louisa Burns Osteopathic Research Committee, it was the consensus that the severity scale be reduced from 5 to 3, automatically reducing variability and thereby creating

greater consistency. Those clinicians who prefer the more detailed five-point scale can adapt the form by inserting plus (+) or minus (–) signs in the scale at level 2. A three-point scale also is in agreement with the mandated hospital form, Osteopathic Musculoskeletal Examination of the Hospitalized Patient. The "other treatment" (other than OMT) columns were deleted because they did not contribute the needed general data sought, and other treatments can be listed in the "plan" section of the form. The "comments" area was deleted, as it was not being used in either data-set group. The listing of specific groups of medication was deleted to allow more room for other data, and it was thought that medications could all be written in the same section and separated out later if needed for a specific study.

A "Treatment method" area was added with a listing of specific abbreviations of techniques that could be used for each region. Circling these abbreviations shortens the documentation time. A box for "sex" (male or female) was deemed necessary and added to the form. For ease in tracking frequency of visits, boxes were added for "follow-up." Insert boxes with billing reminders and boxes for "minutes spent with the patient" for those counseled greater than 50% of the visit time, as well as specific titles in the history section (CC, HPI, ROS/PFSH,

Meds) were added to aid the practitioner in determining coding level for reimbursement. These guidelines were obtained from the May 1997 guidelines of the American Medical Association and Health Care Financing Administration.

We understand that those sections of the SNF that involve coding will need to be updated periodically, and updates are planned approximately every 2 to 3 years, sooner if needed.

A reminder box for the severity scale is included. Completing the "Methods Used to Examine" (the TART criteria box) fulfills the physician's need to record examination methods and is a quick way for documenting musculoskeletal findings. A box for "First Visit" in the "Physicians' evaluation of patient prior to treatment" area was added to avoid confusion and also to indicate the first visit of a new problem. The order of some of the components was changed for better note flow.

The abbreviations used on the form are explained in detail in the "Usage Guide." That guide can be found in the Appendix. The final revised Outpatient Osteopathic SOAP Note Form (*Figure*) was designed to be sufficiently versatile to permit the form to be tailored to individual practice and research studies, while allowing certain standard information to be easily collected at the same time with little added effort. This form is recommended for use in our osteopathic training programs to remind and encourage students to at least examine, if not treat, the musculoskeletal components of disease processes. Preliminary feedback in this setting has proved successful.

Because the SNF is easy to use, collects more pertinent and vital information, and essentially takes no more time to complete, the use of the SNF by all osteopathic physicians would provide the potential of having large amounts of reliable data available for multicenter research purposes. With physicians' permission to release copies of this information to a central database, multiple forms of statistically valid research could be completed on many different medical diseases and dysfunctions and accomplished within a very reasonable time.

Comment

Essentially all information recorded in the PPN was recorded on the SNF.⁵ In addition, the SNF form contained additional information not found in the PPN, most notable being the severity of detected somatic dysfunctions. Information, such as severity and response to treatment of detected somatic dysfunction, would not necessarily be part of the routine medical record but are extremely important for research data collection. Of importance also is that physicians thought that filling in the SNF took the same amount of time as filling in the PPN. This is a key factor in acceptance of the SNF into clinical practice and its widespread use as a research tool.

Of the 76 statistical variables compared, all but 17 were significantly different between the PPN data set and the SNF data set, with the greater content of information almost always being found with the SNF data set. The "Region Evaluated" section exhibited greater than 50% missing data; the "Comment" section contained essentially no data. Through the efforts of this study, we validated that the Outpatient Osteopathic SNF accurately reflects what is recorded in the PPN.

A valid, standardized, and easily incorporated osteopathic outcomes form is essential to document change in somatic dysfunction. Such a form is vital to the development of the osteopathic medical profession and in explaining our practice and philosophy to the medical, legal, and insurance communities. Only through valid and consistent documentation can the profession hope to obtain the required outcome information. This Outpatient Osteopathic SNF is the necessary first step toward specific outcome studies involving patients treated for their somatic dysfunction.

Acknowledgment

Special thanks are given to those who, in addition to the lead author (S.L.S.), served as site investigators: Mark Canteri, DO; Brad Sandler, DO; Hugh Ettlinger, DO; John Hohner, DO; Steve Leifheit, DO; Joel Stein, DO; Kenneth Nelson, DO; Al Turner, DO; and Rebecca Harris, DO.

References

1. Seffinger MA, Friedman HD, Johnston WL. Standardization of the hospital record for osteopathic structural examination: Recording of musculoskeletal findings and somatic dysfunction diagnosis. *JAOA* 1995;95:90-96.
2. Chila AG. Osteopathic Clinical Research *Osteopathic Annuals* 1983;11(7):1-67.
3. Korr IM. Osteopathic research: The needed paradigm shift. *JAOA* 1991;91:161-168.
4. Ross-Lee B, Weiser MA. Healthcare regulation, past, present, and future. *JAOA* 1994;94:74-78.
5. Noursis MJ. *The SPSS Guide to Data Analysis for SPSS/PC1*, 2nd edition. Chicago, Ill: SPSS, Inc; (Current version in use: SPSS96 for WINDOWS); pp 148-416.

APPENDIX

Outpatient Osteopathic SOAP Note Form

Office of: _____

Patient's Name: _____

Section I

Sex: _____

Male ☐

Female ☐

For office use only

Date: _____

Age: _____

Vital Signs: B/P _____

Pulse _____

Respir. _____

Temp. _____

Wt. _____

Ht. _____

S CC: _____

HPI: _____

Section II

ROS/PFSH: _____

Meds: _____

O

Section III

Methods Used to Examine

T ☐ A ☐ R ☐ passive active

Severity Scale: _____

1 No SD or background (BG) levels 2 Obvious TART (esp. R and T), +/- symptoms
3 More than BG levels, minor TART 4 Key lesions, symptomatic, R and T stands out

Level:
2 1-3 HPI
3 1-3 HPI, 1 ROS
4 4+ HPI, 2-9 ROS,
1 PFSH
5 4+ HPI, 10+ ROS,
2+ PFSH

Level of GMS
2 1-5 elements
3 6+ elements
4 2+ from each of 6 areas
5 2+ elements from each of 9 areas

Region	Severity				Somatic Dysfunctions and Other Systems	OMT		Treatment Method	Response			
Evaluated	0	1	2	3		Yes	No		(Circle Treatment Methods Used)	R	I	U
Head	☐	☐	☐	☐		☐	☐	ART / BLT / CR / CS / DIR / FPR / HVLA IND / INR / LAS / ME / MFR / ST / VIS	☐	☐	☐	☐
Cervical	☐	☐	☐	☐		☐	☐	ART / BLT / CR / CS / DIR / FPR / HVLA IND / INR / LAS / ME / MFR / ST / VIS	☐	☐	☐	☐
Thoracic T1-4	☐	☐	☐	☐		☐	☐	ART / BLT / CR / CS / DIR / FPR / HVLA IND / INR / LAS / ME / MFR / ST / VIS	☐	☐	☐	☐
T5-9	☐	☐	☐	☐		☐	☐	ART / BLT / CR / CS / DIR / FPR / HVLA IND / INR / LAS / ME / MFR / ST / VIS	☐	☐	☐	☐
T10-12	☐	☐	☐	☐		☐	☐	ART / BLT / CR / CS / DIR / FPR / HVLA IND / INR / LAS / ME / MFR / ST / VIS	☐	☐	☐	☐
Lumbar	☐	☐	☐	☐		☐	☐	ART / BLT / CR / CS / DIR / FPR / HVLA IND / INR / LAS / ME / MFR / ST / VIS	☐	☐	☐	☐
Sacrum/Pelvis	☐	☐	☐	☐		☐	☐	ART / BLT / CR / CS / DIR / FPR / HVLA IND / INR / LAS / ME / MFR / ST / VIS	☐	☐	☐	☐
Pelvis/Innom.	☐	☐	☐	☐		☐	☐	ART / BLT / CR / CS / DIR / FPR / HVLA IND / INR / LAS / ME / MFR / ST / VIS	☐	☐	☐	☐
Extremity lower	R	☐	☐	☐		☐	☐	ART / BLT / CR / CS / DIR / FPR / HVLA IND / INR / LAS / ME / MFR / ST / VIS	☐	☐	☐	☐
	L	☐	☐	☐		☐	☐	ART / BLT / CR / CS / DIR / FPR / HVLA IND / INR / LAS / ME / MFR / ST / VIS	☐	☐	☐	☐
Extremity upper	R	☐	☐	☐		☐	☐	ART / BLT / CR / CS / DIR / FPR / HVLA IND / INR / LAS / ME / MFR / ST / VIS	☐	☐	☐	☐
	L	☐	☐	☐		☐	☐	ART / BLT / CR / CS / DIR / FPR / HVLA IND / INR / LAS / ME / MFR / ST / VIS	☐	☐	☐	☐
Ribs	☐	☐	☐	☐		☐	☐	ART / BLT / CR / CS / DIR / FPR / HVLA IND / INR / LAS / ME / MFR / ST / VIS	☐	☐	☐	☐
Abd./Other	☐	☐	☐	☐		☐	☐	ART / BLT / CR / CS / DIR / FPR / HVLA IND / INR / LAS / ME / MFR / ST / VIS	☐	☐	☐	☐

Section IV

Physician's evaluation of patient prior to treatment: First Visit ☐ Resolved ☐ Improved ☐ Unchanged ☐ Worse ☐

A

1. _____

Section V

2. _____

P

OMT performed as above: 1-2 areas ☐ 3-4 areas ☐ 5-6 areas ☐ 7-8 areas ☐ 9-10 areas ☐

Meds: _____

PT: _____

Exercise: _____

Section VI

Nutrition: _____

Minutes spent with patient: ☐ 10 ☐ 15 ☐ 25 ☐ 40 ☐ 60 ☐ >60

Follow-up: ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 8 ☐ 11 ☐ 12

Units: ☐ Days ☐ Wk. ☐ Mo. ☐ Yr. ☐ PRN

Signature of the examiner: _____

Medical Decisions:
2 Minimal decisions
3 Limited decisions
4 Moderate decisions
5 Excessive decisions
(based on # of options, complexity of records, risk of significant complications.)

APPENDIX continued

Outpatient Osteopathic SOAP Note Form Usage Guide

Introduction:

The following Outpatient Osteopathic SOAP Note Form was developed and tested 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 boxed areas are critical to research data and should be filled in. Data will be collected and analyzed by a computer. Additions to the form can be made. If data was not obtained for a certain section, leave it blank. 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-handed corner and reading to the right and down.

Section I: Headings and Identifications

Patient's

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

Date: Write in the date of the patient's visit.

Sex: Fill in the box after Male or Female with regards to the patient's gender.

Age: Write in the patient's age in years.

The boxes marked "Office of:" and "For office use only:" can be used for research studies, office record keeping or anyway you'd like.

Vital Signs: Write in the corresponding vital signs on the lines provided labeled B/P (blood pressure), Pulse, Respir. (respirations), Temp (temperature), Wt (weight) and Ht (height). An R (regular) or an I (irregular) can be placed after the number for pulse if known. If a measurement was not taken, leave the space blank.

Section II: Subjective

S: for the **SUBJECTIVE** part of the **SOAP** note.

CC: Stands for **CHIEF COMPLAINT** which is a concise statement describing the symptom, problem, condition, diagnosis or other factor

that is the reason for the encounter, usually stated in the patient's words.

HPI: Stands for **HISTORY OF PRESENT**

ILLNESS which 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, timing, context, modifying factors, and associated signs and symptoms significantly related to the presenting problem(s).

ROS: Stands for **REVIEW OF SYSTEMS** which is an inventory of body systems obtained through a series of questions seeking to identify signs and/or symptoms which the patient may be experiencing or has experienced which are pertinent to the chief complaint. For the purposes of CPT the following elements of a system review have been identified:

Constitutional symptoms, Eyes, Ears/Nose/Mouth/Throat, Cardiovascular, Respiratory, Gastrointestinal, Genitourinary, Musculoskeletal, Integumentary, Neurological, Psychiatric, Endocrine, Hematologic/Lymphatic, Allergic/Immunologic. The review of systems helps define the problem, clarify the differential diagnoses, identify needed testing, or serves as baseline data on other systems that might be affected by any possible management options.

PFSH: Stands for **PAST, FAMILY, SOCIAL HISTORY**. The **PAST HISTORY** is a review

APPENDIX continued

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. The **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 System Review; diseases of family members which may be hereditary or place the patient at risk. The **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.

MEDS: Write in the current **MEDICATIONS**, dosage, route and frequency of administration.

LEVEL: This is a guide for criteria needed to be used to justify your evaluation and management CPT code in the subjective section. Circle the level that applies.

2 1-3HPI: This stands for a level two visit requiring one to three History of Present Illnesses. This is also known as *Problem Focused*.

3 1-3HPI, 1ROS: This stands for a level three visit requiring one to three History of Present Illnesses and one Review of System. This is also known as *Expanded Problem Focused*.

4 4+HPI, 2-9ROS, 1PFSH: This stands for a level four visit requiring four or more History of Present Illnesses, two to nine Review of Systems and one component of Past, Family or Social History. This is also known as *Detailed*.

5 4+HPI, 10+ROS, 2+PFSH: This stands for a level five visit requiring four or more History of Present Illnesses, ten or more Review of Systems and two or more of Past, Family or Social History. This is also known as *Comprehensive*.

Section III: Objective

0: for the **OBJECTIVE** section of the **S_OAP** note. Put your physical exam findings for areas/systems in this section. Gait and station as well as inspection and/or palpation of digits and nails for the GMS 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.

LEVEL GMS: This is a guide for criteria needed to be used to justify your evaluation and management CPT code in the objective section for the **GENERAL MULTI-SYSTEM EXAMINATION (GMS)**. The following body parts and organ systems are recognized: Constitutional, Eyes, Ears/Nose/Mouth/Throat, Neck, Respiratory, Cardiovascular, Chest(Breasts), Gastrointestinal(Abdomen), Genitourinary, Lymphatic, Musculoskeletal, Skin, Neurologic, Psychiatric. See the CPT book for definitions of elements and bullets. Circle the level that applies.

2 1-5 Bulleted elements: For a level two visit you must have examined one to five elements identified by a bullet. This is also known as *Problem Focused*.

3 6+ Bulleted elements: For a level three visit you must have examined at least six elements identified by a bullet. This is also known as *Expanded Problem Focused*.

4 2+ Bulleted elements from each of 6 areas OR 12+ elements in 2+ areas: For a level four 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. This is also known as *Detailed*.

5 2+ Bulleted elements from each of 9 areas: For a level five 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. This is also known as *Comprehensive*.

APPENDIX continued

Be advised for the musculoskeletal section of the **General Multi-system Exam** the six areas are: 1) head and neck; 2) spine, ribs and pelvis; 3) right upper extremity; 4) left upper extremity; 5) right lower extremity; 6) left lower extremity.

Warning: To fulfill the elements for anyone of the above areas, in addition to indicating **TART** findings you must also include an examination of **gait and station** and **inspection and/or palpation of digits and nails**.

Section IV: Musculoskeletal Table

METHODS USED TO EXAMINE: Be sure to blacken in the rectangles indicating the tools you used for your examination (T, A, R, T). Included in the definition of these components is the criteria required for coding in each body area.

- 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 rectangles is a shortcut to a full narrative documentation in the Somatic Dysfunction section.

REGION EVALUATED: This is a list of musculoskeletal body regions arranged in order based on the ICD-9 diagnoses. They include: Head; Cervical; Thoracic; Lumbar; Sacral; Pelvis; Lower Extremities; Upper Extremities; Rib Cage; Abdomen and other (viscera falls into this category). The thoracic region is broken down into three parts based on vertebral levels for specificity: T1-4, T5-9 and T10-12. This was done for ease in listing interrelationships between systems.

SEVERITY: This section refers to the severity (**None (0), mild (1), moderate (2), severe (3)**) of the most effected somatic dysfunction in a region. Fill in one box for each region examined. For regions that are not examined leave the box 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 elements, may or may not be overtly symptomatic but significant R and/or T.
- 3 Severe****KEY LESIONS**, significant symptomatic, stands out; R and/or T elements stand out with minimum search or provocation.

(In the center of the table is a quick reference for the severity scale.)

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 (PSNS); lymphatic (LYM); cardiovascular (CV); respiratory (RESP); gastrointestinal (GI); fascial (FAS); etc. components. Use standard terminology. **If you filled in boxes under TART you do not need to write anything here for coding purposes but it is a good section to put in your notes for personal use.**

OMT: If boxes 0, 1, 2, or 3 are filled in under severity then there **must** be a mark in the OMT section for that same region. Fill in the YES box if Osteopathic Manipulative Treatment (OMT) was performed or the No box if no OMT was performed for each region examined.

TREATMENT METHOD: Listed here are the abbreviations approved by the profession for the treatment modalities used to treat the somatic dysfunctions listed previously. Circle the modalities used in each region treated.

- ART:** articular treatment
- BLT:** balanced ligamentous tension treatment/ ligamentous articular strain treatment

APPENDIX continued

- CR:** cranial treatment/osteopathy in the cranial field/cranial osteopathy
CS: counterstrain treatment
DIR: direct treatment
FPR: facilitated positional release treatment
HVLA: high velocity/low amplitude treatment
IND: indirect treatment
INR: integrated neuromuscular release
LAS: ligamentous articular strain treatment/balanced ligamentous tension treatment
ME: muscle energy treatment
MFR: myofascial release treatment
ST: soft tissue treatment
VIS: visceral manipulative treatment

RESPONSE: Fill in one box for each region of somatic dysfunction that was treated with OMT. This is the physicians perception of how the somatic dysfunctions in each region responded to Osteopathic Treatment immediately after treatment. The boxes are indicated as follows:

- R:** The somatic dysfunction is completely **RESOLVED** without evidence of it having ever 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 after treatment.

PHYSICIAN'S EVALUATION OF PATIENT

PRIOR TO TREATMENT: This is the physician's overall opinion of how well the patient is doing based on his or her objective findings of the patient prior to treatment compared to the last visit.

FIRST VISIT: If this is the patients first visit for a particular problem, mark the rectangle after first visit.

RESOLVED: The problems for which the patient is following up on are resolved. This implies that if a patient presents for a follow up on a musculoskeletal problem, there are no findings in the table under the somatic dysfunction section. However, the region assessed could be

checked with zero severity indicating that no somatic dysfunction was found.

IMPROVED: The problems for which the patient is following up on are improved but not totally resolved.

UNCHANGED: The problems for which the patient is following up on are no different or completely unchanged from the way they were at the prior visit. This implies that for musculoskeletal problems the general severity of the overall somatic findings in a patient are similar to what they were at the last visit even if they are not exactly the same. This may also happen if you evaluate or consult on a patient at one visit but do not institute any treatment at that visit.

WORSE: The problems for which the patient is following up on are worse then they were at the last visit. This could occur with a musculoskeletal problem if no treatment was started at the last 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 how the patient is at the current visit. This does not reflect how their early delayed response, i.e. "flare up", from the last treatment was. Flare up information can be charted in the subjective section of the note.

Section V: Assessment

A: for the **ASSESSED** section of the SOAP **A**P note.

1-4 spaces are available fro ICD-9 diagnoses to be listed in the order of their importance.

Section VI: Plan

P: for the **Plan** Section of the SOAP **P** form.

OMT PERFORMED AS ABOVE: Fill in the box for the number of regions of somatic dysfunction that were treated. This number should correlate with the number of YES boxes in the OMT section of the table and the number of boxes in the severity section of the table marked one, two, or three. Beware that although the Thoracic region is divided into three sections on the table it only counts as **one** region for CPT coding. The boxes are as follows:

APPENDIX continued

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.

MEDS: List in this space any medications the patient will continue on or new medication that will be started.

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 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 does, has received in the office or you recommend they receive.

OTHER: List in this space anything that doesn't 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 what topics were discussed, what details were included, what handouts or educational material were given and what referrals were made. Then choose your CPT code based on time spent. Examples: 99212 for 10 minutes, 99213 for 15 minutes, 99214 for 25 minutes and 99215 for 40 minutes spent. If longer than 40 minutes was spent in counseling look at the prolonged service codes.

MEDICAL DECISIONS: This is a guide for criteria needed to be used to justify your evaluation and management CPT code in the Plan section. It is based on the number of options, complexity of records and risk of significant complications. Circle the level that applies.

2 Minimal Decisions: This stands for a level two visit requiring *minimal decision making*.

3 Limited Decisions: This stands for a level three visit requiring *limited decision making*.

4 Moderate Decisions: This stands for a level four visit requiring *moderate decision making*.

5 Extensive Decisions: This stands for a level five visit requiring *extensive decision making*.

MINUTES SPENT WITH PATIENT: Fill in the box 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 or >60 minutes. These correspond to the time allotments in the CPT book. Choose the one that best fits.

FOLLOW-UP AND UNITS: Fill in the boxes that corresponds to when you would like to see the patient again both in number and units. For example for one month fill in the box above 1 and the box above Mo.(month). Other abbreviations are as follows: Days, Wk.(week), Yr.(year) and PRN(as needed).

SIGNATURE of the examiner: Write your signature in this space.

APPENDIX continued

Outpatient Osteopathic SOAP Note Form

Office of:

Patient's Name: Jane Doe

Sex: Male ☐

Female ☒

For office
use only:

Date: 1/1/98

Age: 25

Vital Signs: B/P 120/80 Pulse 80 Respir. 20 Temp. 98.6 Wt. 130 Ht. 5' 5"

S cc: Stomachache, Back pain @ flex/ld p qm

HPI: Started 2 days ago, hurts mostly mid epigast

8 mid back, 8 radiation, Eatt ing & bed rest help

ROS/PFSH: ~~no~~ trauma, Dad deceased 46yrs of PUD

Meds: Norflex 100mg, B12

0 Abcd - tender epigastrium, ⊕ bowel sounds, & masses.

UE bilat. muscle strength 5/5

Level:

2 1-3 HPI

3 1-3 HPI, 1 ROS

4 4+ HPI, 2-9 ROS,
1 PFSH

5 4+ HPI, 10+ ROS
2+ PFSH

Level of GMS

- 2 • 1-5 elements
- 3 • 6+ elements
- 4 • 2+ from each of 6 areas
- (or) 12+ elements in 2+ areas
- 5 • 2+ elements from each of 9 areas

Methods Used to Examine

Method	Passive	Active
T	■	■
A	■	■
R	■	■

Severity Scale:

Severity	Description
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 stands out

Region	Severity				Somatic Dysfunctions and Other Systems	OMT		Treatment Method	Response			
Evaluated	0	1	2	3	MS / SNS / PNS / LYM. / CV / RESP. / GI / FAS. / etc.	Yes	No	(Circle Treatment Methods Used)	R	I	U	W
Head	☐	☒	☐	☐	parietal and tender to touch	☐	☐	ART / BLT / CR / CS / DIR / FPR / HVLA IND / INR / LAS / ME / MFR / ST / VIS	☐	☐	☐	☐
Neck	☐	☐	☒	☐		☐	☐	ART / BLT / CR / CS / DIR / FPR / HVLA IND / INR / LAS / ME / MFR / ST / VIS	☐	☒	☐	☐
Thoracic T1-4	☐	☐	☐	☒	T ₃ L T ₅ R 1	☐	☐	ART / BLT / CR / CS / DIR / FPR / HVLA IND / INR / LAS / ME / MFR / ST / VIS	☐	☐	☒	☐
T5-9	☐	☐	☐	☒	T ₅ R T ₇ L (FI)	☐	☐	ART / BLT / CR / CS / DIR / FPR / HVLA IND / INR / LAS / ME / MFR / ST / VIS	☐	☐	☒	☐
T10-12	☐	☐	☒	☐	T ₁₀ F ₅ R ₂	☐	☐	ART / BLT / CR / CS / DIR / FPR / HVLA IND / INR / LAS / ME / MFR / ST / VIS	☐	☐	☒	☐
Lumbar	☐	☐	☒	☐	myofascial strain	☐	☐	ART / BLT / CR / CS / DIR / FPR / HVLA IND / INR / LAS / ME / MFR / ST / VIS	☐	☒	☐	☐
Pelvis/Sacrum	☒	☐	☐	☐	WDL	☐	☐	ART / BLT / CR / CS / DIR / FPR / HVLA IND / INR / LAS / ME / MFR / ST / VIS	☐	☐	☐	☐
Pelvis/Innom.	☐	☐	☐	☐		☐	☐	ART / BLT / CR / CS / DIR / FPR / HVLA IND / INR / LAS / ME / MFR / ST / VIS	☐	☐	☐	☐
Extremity lower	^R _L	☐	☒	☐	Abductor tender TFL	☐	☐	ART / BLT / CR / CS / DIR / FPR / HVLA IND / INR / LAS / ME / MFR / ST / VIS	☐	☒	☐	☐
Extremity upper	^R _L	☐	☐	☐	Abduction 160°	☐	☐	ART / BLT / CR / CS / DIR / FPR / HVLA IND / INR / LAS / ME / MFR / ST / VIS	☐	☐	☐	☐
Ribs	☐	☐	☐	☐		☐	☐	ART / BLT / CR / CS / DIR / FPR / HVLA IND / INR / LAS / ME / MFR / ST / VIS	☐	☐	☐	☐
Other/Abd.	☐	☐	☐	☒	↓ mobility stomach greater curvature	☐	☐	ART / BLT / CR / CS / DIR / FPR / HVLA IND / INR / LAS / ME / MFR / ST / VIS	☐	☐	☐	☒

Physician's evaluation of patient prior to treatment: First Visit ☐ Resolved ☐ Improved ☐ Unchanged ☒ Worse ☐

A 1. Gastritis 3. S/D T/R/L/E/W/C/H/L

2. Thoracic strain 4.

P

OMT performed as above: 1-2 areas ☐ 3-4 areas ☐ 5-6 areas ☐ 7-8 areas ☒ 9-10 areas ☐

Meds: Add Prilosec 20mg po qd PT: Hot Packs done

Neat at home to Thoracic area

Exercise: shoulder stretches Other: Emotional Support given

Answer

Nutrition: Bland diet

Minutes spent with patient: ☐ 10 ☐ 15 ☒ 25 ☐ 40 ☐ 60 ☐ > 60

Follow-up: 1 2 3 4 5 6 8 11 12

Medical Decisions:

- 2 Minimal decisions
- 3 Limited decisions
- 4 **Moderate decisions**
- 5 Excessive decisions:

(based on # of options, complexity of records, risk of significant complications.)

Signature of
the examiner:

03MX2M.PCX SS/WAK 5/98

Funded under a grant from the AOA Bureau of Research ©American Academy of Osteopathy