Sample SOAP note considerations

S (Subjective)	Patient reported pain: Location of pain (specific areas in the low back, radiation to legs if present) Quality of pain (aching, sharp, stabbing) Severity of pain (scale of 1-10) Onset of pain (when it started, any specific event) Aggravating factors (activities, postures that worsen pain) Relieving factors (positions, activities that ease pain) Impact on daily activities (limitations in work, hobbies, self-care) Past medical history: Previous back injuries or surgeries Relevant medical conditions (arthritis, disc herniation) Social history: Occupation and physical demands Lifestyle factors (exercise habits, smoking, weight)
O (Objective)	Observation: Gait pattern (limp, asymmetry) Posture (slouched, lumbar lordosis) Range of motion (ROM) assessments Muscle strength testing (key back muscles, hip flexors, hamstrings) Special tests (e.g., straight leg raise, slump test if indicated) Functional assessments: Ability to bend and lift, sit and stand, perform daily activities (e.g., reaching, lifting groceries)
A (Assessment)	Diagnosis: Chronic low back pain (specify if related to a specific condition if known) Clinical reasoning: Analysis of subjective and objective findings Contributing factors to pain (muscle imbalances, postural issues, biomechanics)

P (Plan)	Treatment interventions:
----------	--------------------------