Outpatient Osteopathic Cranial SOAP Note Form
Usage Guide

Introduction:

The following is an adaptation of the Outpatient Osteopathic SOAP Note Form developed and tested by the American Academy of Osteopathy's Louisa Burns Osteopathic Research Committee under a grant from the American Osteopathic Association. The original form has been validated and standardized, and is recommended for research and training in osteopathic medicine. The adaptation is also the result of input from the Louisa Burns Osteopathic Research Committee, and has been revised from the recommendations of many cranial osteopathic physicians across the country who teach and do research in the field of cranial osteopathy. This particular format is designed to accommodate the needs of research data collection, so does not include the same identifying data or billing information as the original.

Instructions for Use:

Print where stated. All printing or writing must be legible to anyone. Blacken the appropriate rectangles. All boxed areas should be filled in. Additions to the form can be made. If data was not obtained for a certain section, leave it blank. All data should be recorded at the time of the exam. All definitions were obtained from the CPT book and 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. This form should be filled out simultaneous with the exam by a person different from the osteopathic examiner.

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Section I: Headings and Identifications

FORM 3: The numbers following the identification of this form are the patient's identification number; the first two digits are your particular center’s number, and the next three are the number assigned by the central coordinator to your patient at the time of randomization. This number reflects the order in which the patient was assigned.

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

Month in Study for Randomization: Note how long the patient has been in the study. There may be more than one visit for that particular month.

Treatment Number: If this patient is in the treatment group, please note which treatment this is.

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Section II: Subjective

S: for the SUBJECTIVE part of the SOAP note.

Osteopathic History since last visit: This should include any information of relevance to the child's osteopathic treatment, including any reaction to the previous treatment, any injuries to the body or head since last seen (note which side of the body if known), or any information volunteered by the parent about the benefit or problems with the treatment.
**Section III: Objective**

**O:** for the **OBJECTIVE** part of the **S**OAP note. Put in your physical exam findings for areas/systems in this sections. 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. Particularly note any areas of bruising or other indications of injury, and which side is affected.

**GENERAL SYMMETRY and POSTURE:** Write in your description of the patient's body parts and postural characteristics.

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**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 are the criteria required for coding in each body area.

- **T:** TISSUE TEXTURE CHANGE, stability, laxity, effusions, tone
- **A:** ASSYMMETRY, 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 ECD-9 diagnoses. They include: Head (see more detail below); Cervical; Thoracic; Lumbar; Sacral; Pelvis; Lower Extremities; Upper Extremities; Rig 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.

**HEAD**

**ASYMMETRY:** Note any variation in head symmetry, triangular shaped head (whether wide part is anterior or posterior), eye position, size of palpebral fissures, position of ears, flattening of cheek, etc. Note any prominent ridging of sutures, parietal horns, frontal bossing, etc. if present.

**CRI/PRM, Amp, Vitality.** This is a description of the Cranial Rhythmic Impulse, or Primary Respiratory Mechanism. Rate the vitality and amplitude according to the severity of dysfunction, not according to the function (see **SEVERITY** below). If there is no asymmetry noted, put the same number in both "right" and "left column. Time the rate of the impulse, and note whether it is Low (0-5 cycles/min), Moderate (6-10 cycles/min), or High (>11 cycles/min). One cycle includes both a full expansion (flexion) and contraction (extension) of the Mechanism. Note if lateral fluctuation is present.

**STRAIN PATTERNS:** This category describes somatic dysfunction at the sphenosellar symphysis (SBS) and the cranial base in general. SBS compression implies a head with fairly symmetric rigidity and very little movement in flexion and extension, or may be held in predominantly flexion or extension. If it is possible to grade the severity, do so, but otherwise mark "2" in both "R/Ant/Sup" and "Lt/Post/Inf" columns for this and all other dysfunctions that are either present or absent, and/ or have no laterality.

**TORSION** (Tor) pattern of SBS: named by which side the sphenoid is high.

**SIDE-BENDING/ROTATION (SBR):** named by the side of convexity, or low side of both sphenoid and occiput. Mark the column for which side it is present with a "2", and leave the other blank.
**LATERAL STRAIN (LS):** named by the direction that the sphenoid is most prominent, usually associated with a parallelogram head. Note that column with a "2" and leave the other blank. If you wish to include information about the direction of the rotation at the SBS, or if the sphenoid is more anterior on one side or another, note that in the provided blank space.

**VERICAL STRAIN (VS):** named by what is happening at the SBS, (e.g, superior strain will have external rotation of the frontals with a sense of them going caudad anteriorly, and the opposite with inferior strain.)

**TEMPORAL:** Describes what is happening in each of the temporals
TmC: Intraosseous compression of either temporal. Note if present in either or both in the appropriate column. May be graded in severity or just note "2'.

**INTERNAL ROTATION** – of right or left temporal. Note in one or both columns.

**EXTERNAL ROTATION** - of either or both temporal.

**POSTERIOR:** This is a general description of the area posterior to the coronal suture, including the OA (occipito-atlas) area, Tn (tentorium), PJ (petro-jugular portion of the occipito-mastoid suture), OM (occipito-mastoid suture), La (lambdoid suture), PT (parieto-temporal articulation, including the parietal notch), OcC (intraosseous compression of the occiput, or condylar compression), TMJ (temporomandibular joint), and Man (mandible). We realize the mandible and TMJ look pretty anterior, but the influence of the temporal and occiput on these structures is the deciding factor. If any area stands out as remarkable, note that.

**ANTERIOR:** This is a general description of the area, including the coronal suture and articulations of the sphenoid with temporal and frontal (SS – sphenosquamous, PS – petro-sphenoid, FS – fronto-sphenoid), FrC (intraosseous compression of the frontal at the metopic area), Fac (facial bones, including palatines), and Co (coronal suture). Again, please note any prominent ridging. Note severity for both right and left areas.

**CERVICAL:** this includes CTJ (cervico-thoracic junction) and above. Note any specific diagnostic findings, or if more upper or lower findings.

**THORACIC:** This includes TLJ (thoraco-lumbar junction) and above, including the thoracic outlet/inlet. If unable to separate into upper, middle, and lower, write overall findings in all three, or include middle with lower. Note that there is a separate category for Ribs for more lateral findings.

**LUMBAR:** This includes LSJ (lumbo-sacral junction) and above. Note any specific diagnostic findings.

**SACRUM/PELVIS:** This should include any torsions, flexion, or extension of the sacrum, or intraosseous compression of the sacrum.

**PELVIS/INNOMINATE:** This includes the pubic bone, ischium, ilia

**EXTERNALITY – UPPER:** This should include shoulders and scapulae as well as arms and hands

**EXTERNALITY – LOWER:** This includes hips and any leg, knee or foot malformation

**RIBS:** Note any dysfunction and if more prominent on right or left, anterior or posterior

**DIAPHRAGM/ABD/other:** This will include the diaphragm.
SEVERITY: for every region noted, the scoring will be 0-3 based upon the degree of abnormality always. 0=no abnormality, 1=mild abnormality, 2=moderate abnormality, 3=severe abnormality. We realize this is a judgement call, but try to quantify. Think of it as a bell-shaped curve of abnormality. Most folks needing OMT will have moderate dysfunction in the areas expected. Few will have none, and some will have severe, but the actual range of severe may be quite broad. If the finding is either "present" or "absent", code it as a "2" if it is present. For regions that are not examined, leave the box empty. If a rectangle is not marked in a region, it is assumed that the region was not examined. The scale is as follows:

0 None......No somatic dysfunction present of 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.

There is a separate column for right or left, which may instead be anterior or posterior (for midline structures), or superior or inferior (for vertical strains). If right and left are the same, (e.g., there is no laterality present,) just code the same in both sides, all throughout the form. (In the center of the table is a quick reference for the severity scale.)

Predominantly Art/Mem: If the somatic dysfunction is noted to be mostly articular, or osseous, note this in the "Art" column; if it is mostly Membranous (or fluid), note this in the "mem" column.

SOMATIC DYSFUNCTION & OTHER SYSTEMS: Somatic Dysfunction is defined as impaired or altered function or 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); 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 somatic dysfunction was noted and treated, mark "yes" in the OMT column.

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.

The head area may get BMT (balanced membranous tension, realizing the cornerstone of any other method is in order to obtain BMT), CV4 (compression of the fourth ventricle), DIR ACT (direct action), DIS (distraction; or separation at the suture), EXAG (exaggeration, an indirect approach), FLD (directing the tide, usually from the opposite side of the head, but may include lateral fluctuation), Molding (a direct technique used mostly on newborns), OPM (opposite physiologic motion), VENSIN (venous sinus drainage technique), or Other (fill in the blank).

Other areas of the body from cervical to diaphragm, may use among the following modalities: ART (articulation), BLT (balanced ligamentous tension), BMT (balanced membranous tension, primarily on the sacrum), CR (cranial treatment/osteopathy in the cranial field (most often on sacral dysfunctions), CS (counterstrain), FPR (facilitated positional release), HVLA (high velocity, low amplitude, or “impulse”), ME (muscle energy), MFR (myofascial release), ST (soft tissue), VIS (visceral), and Other (fill in the blank).
**RESPONSE**  Fill in one box 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 OMT immediately after treatment. The boxes are indicated as follows:

- **R** (resolved) indicates the dysfunction shows no evidence of having ever been present, or a remarkably significant release; **I** (improved) will be used predominantly, and will cover a broad range, where there is still somatic dysfunction noted; **U** (unchanged) will describe areas that do not respond, or were the same after treatment as before; **W** (worse) is an area that was aggravated after treatment.

**PRE-TREATMENT PALPATORY EVALUATION:**  This is not the place to note a response to treatment of this visit. This is the physician's overall opinion of how well the patient is doing based on his or her objective finding prior to treatment compared to the last visit.  

**FIRST VISIT:**  If this is the patient's first visit for a particular problem, mark this rectangle.

**RESOLVED:**  The problems for which the patient is following up are resolved.

**IMPROVED:**  The problems are improved but not totally resolved.

**WORSE:**  The problems for which the patient is following up are worse than when 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.

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**SECTION V: ASSESSMENT**

**A:** for the assessment part of the SOAP note.

1-4 spaces are available for ICD-9 diagnoses to be listed in the order of their importance. This section is not necessary to complete each time for the purpose of the study, if there is not change from the initial diagnosis. Note, however, if there are any other concurrent medical problems present.

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**P:** for the plan part of the SOAP note.

**Specific Instruction:**  Anything you have told the patient to do before the next appointment, including any exercise, instructions for lymphatic pump, etc. should be recorded here.

**Next Visit:**  Record when the patient is to be seen again, including the time.

**Other data pending completion:**  Record any information which would be a useful reminder to keep track of data not yet collected, or appointments to be made, or other professionals to contact, such as audiologist, or primary physician's office to review chart.

**SIGNATURE of the transcriber:**  The site coordinator should sign here.

**SIGNATURE of the examiner**  The treating osteopathic physician should sign here.