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PT SOAP Note Template

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PATIENT	DATE OF SERVICE	VISIT NUMBER

DIAGNOSIS	THERAPIST

S · SUBJECTIVE

Pain rating and location, what the patient can and cannot do this week, home exercise adherence, new complaints.

O · OBJECTIVE

Range of motion, strength, special tests, gait, balance. Interventions given, with minutes and parameters.

A · ASSESSMENT

Progress toward each goal, response to treatment today, and why skilled care is still needed.

P · PLAN

Frequency and duration left on the plan of care, focus of the next visit, home program changes.

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PT SOAP Note Example: After Knee Surgery

FICTIONAL EXAMPLE. NOT A REAL PATIENT. FOR ILLUSTRATION ONLY.

PATIENT	**DATE OF SERVICE**
T. Nguyen (fictional), 64	11/19/2026
VISIT NUMBER	**DIAGNOSIS**
6 of 12	Right total knee replacement, 10/28/2026
THERAPIST	
Sam Ortiz, PT, DPT	

S · SUBJECTIVE

Reports right knee pain 4/10 at rest and 6/10 on stairs, down from 7/10 last week. Walks around the house without the walker. Still uses one crutch outside. Doing the home exercises twice a day. Sleeping better.

O · OBJECTIVE

Knee flexion 98 degrees active, 104 passive (last visit 90 active). Extension lacks 5 degrees. Quad lag 0. Straight leg raise 3 sets of 10 without lag. Stationary bike 8 minutes, full revolutions. Gait with one crutch, mild antalgic pattern, step-to on stairs. Manual therapy to the patellofemoral joint 10 minutes. Ice 10 minutes after.

A · ASSESSMENT

Flexion improved 8 degrees in one week and is on track for the 110 degree goal by visit 12. Extension deficit and stair pattern still limit community walking. Needs skilled care to progress range of motion and gait training.

P · PLAN

Continue twice a week for 3 more weeks. Next visit: step-ups and reciprocal stair training. Add prone knee hangs to the home program, 3 times a day for 3 minutes.