

# OT SOAP NOTES

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S

## SUBJECTIVE INFORMATION

What the client/family states or presents as relevant to therapy, (Think of it as your client's current status, behavior, or answers to your questions)

O

## OBJECTIVE INFORMATION

Specific tasks performed during the treatment session to address the client's goals (Measurable, quantitative, and observable actions during the session)

A

## ASSESSMENT

How the client did or how they responded during the treatment. (Think of it as adding validity and interpreting the information written in the S and O sections.)

P

## PLAN

What you intend to do next time to address how the client responded this time such as next steps, revisiting of steps, etc. (Think of it as your treatment plan for next time.)

# Ot Soap Note Documentation

**R Bogdan**



**Ot Soap Note Documentation:**

Uncover the mysteries within Explore with is enigmatic creation, **Ot Soap Note Documentation** . This downloadable ebook, shrouded in suspense, is available in a PDF format ( PDF Size: \*). Dive into a world of uncertainty and anticipation. Download now to unravel the secrets hidden within the pages.

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