



What's in a Soap Note- Part 1 – Subjective Complaint

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It's important to understand and properly document a patient encounter. The bottom line is that you must show medical necessity. That is the Medicare way and all other carriers follow suit.

Another important point I want to make is that regardless of your type of practice (cash, PI, family, sports, etc) your documentation should be the same as every other practice. Standardizing notes is a step in the right direction for fewer denied claims and improving your public Chiropractic image.

In this lesson I am going to focus on the Subjective portion of your soap note. The Subjective is one of the easier parts of documenting. To simplify: Why is the patient coming to see you? Now don't get me wrong, writing just LBP or NP isn't going to cut it.

Let's start with an example of a proper documented Subjective complaint:

Alex came in today complaining of neck pain that started on 7/1/2010. He said, "I woke up with a stiff neck last Sunday". The symptoms are bilateral with moderate pain occurring frequently (51-75% of the day). He describes the pain as sharp and stabbing with radiating pain to his right shoulder. Ice and heat do improve the pain although the pain has remained about the same since onset and pain is rated at a 5 on a 1-10 scale (0 being no pain and 10 being excruciating). Pain is aggravated by turning his head from side to side and bending over.

In breaking this down we are covering all of the basics. You may have learned the O.P.Q.R.S.T. acronym when you were in school or at a seminar. This is a great model to stick with and actually documents above and beyond the minimum requirements.

O.P.Q.R.S.T.

- Onset- When did the pain begin?
- Provokes- What makes the main worse?
- Quality- Describe in the patient's words what kind of pain they have.
- Radiates- Does the pain radiate to a body part?
- Severity- What kind of pain level are we talking about?

- Time- When did the pain start and how long has patient had condition?

Using this model is very strong. Medical documentation related to proper E&M coding requires 4 components of the HPI (History of Present Illness) be documented during the initial exam. As you can see, the above model covers 6 of them.

The same process needs to be done for all major complaints. If you prefer to treat them all at once, your initial exam and intake process will be lengthy. Another idea you may consider is to treat only 1 major condition at a time and when one complaint is at a satisfactory level for the patient, you then address the next item on their list. This reduces the documentation burden per visit and allows you and the patient to focus on one item at a time.

The history of this condition should be taken by the doctor directly. Staff does not have the proper training to recognize a risk factor so a doctor should do this portion of intake with the patient. This is something you should keep in mind.



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