S.O.A.P.

Name: _____ Age: _____ Date: _____

Chief Complaint: 1. _____ 2. _____ 3. _____

Initial Onset: _____Episode Duration: _____

Acute: ☐ Recurrent: ☐ Chronic: ☐ *V.A.S. (1-10): _____

PERIPHERAL: ☐ **CENTRAL:** ☐

Mechanical/ Inflammatory: ☐ | Ischemic: ☐ | Cognitive: ☐ | Affective: ☐| Autonomic: ☐

Goals/ Fears/ Worries/ Concerns:	What Do You Think Is Causing The Pain? Treatment Expectations:
Mechanism of Injury (MI) / Past History: Trauma: YES: ☐ NO: ☐ Details: Treatment: Past: Current:	Activity Intolerances: Neurological Signs: Red Flags: Imaging: YES: ☐ NO: ☐

Painful Tests:	Painless Dysfunctions:
Mechanical Sensitivities (MS): Directional Preference: YES: ☐ NO:☐ DIRECTION?: _____	Abnormal Motor Control (AMC):
Activity History: Past: Current: Occupational History:	Initial Self-Care Rx: Initial Treatment:

*V.A.S.: Visual Analogue Scale - scale from 0-10 how bad is the pain.