

ABBREVIATIONS FOR CHARTING

Use as you feel comfortable with the following. Most professionals understand this nomenclature plus it makes description understandable in the least amount of words. This is not a complete list, but a good start.

To use shortened designations, it is just a manner of changing age, marital status, race and gender. Capitalize at sentence beginning as needed.

For example:

22 y.o., SAAM, c/o depression as evidence by . . .

(22 year old, Single African-American male, complaining of depression as evidenced by . . .)

M – Married S - Single W – Widowed D – Divorced N – Non-married

AA – African American H – Hispanic C – Caucasian A – Asian M – Male

F - Female

Abbreviations for phrases and medical symbols

c/o – complaint/complaining of ↑ - increase(d) ↓ - decrease(d) ĉ - with

ŝ - without clt or C(circled) – client th or T(circled) – therapist pt – patient

dx – diagnosis hx – history ER – emergency room + - positive - negative

< - lesser than > - greater than = - equal to @ - at dc – discontinued prn – as

needed R(circled) – right L(circled) – left noc – at night p – after da – daughter

fa – father mo – mother gm – grandmother gf – grandfather bio – biological (bio

mo/bio fa) OPC – order of protective custody GED – general education diploma

CD – chemical dependence UTI – urinary tract infection PCP – primary care physician

OD - overdose

Words to describe (mastering the English language = short, concise notes)

gathered paternal maternal stabilized voluntary involuntary failure

success request(ed) exchange of words admission reliable accompanying

pressure(d) secure volatile prescribed hopelessness helplessness

expressing cleared recommend(ations) interview identified issues struggling

initially conflict(s) dependent independently prompted perpetual steady

relationship role model father/mother figure process function(ing) psychiatric
 facility psychopathology further exploration sporadic constant low grade
 high grade oscillating substantial endorse psychosis episode(s) discrete
 overlapping side effects quality denies admits recreation(al) illicit
 pathology attempt(ed) impulsive compulsive outbursts numerous criteria
 describe victim perpetrator abuse trauma With regards to . . . adamantly
 misuse prescription(s) significant presents allergic reaction(s) voices . . .
 contributory noncontributory as mentioned restructure(ing) legal supportive
 otherwise disheveled self-harm infidelity congruent restricted alert oriented
 mood affect articulate spontaneous anxious nervous goal directed irritable
 irritability disappointed coherent logical extremely suicidal homicidal intention
 desire hallucinations delusions judgment insight limited motivated(ion)
 manage recommendations intelligent chronic acute resistant exacerbates
 dynamics manifested behavior potential status appropriate compliant(ance)
 precaution(s) revisit substantial support system safety structure opportunity
 resolution solution(s) remedy(ies) self-destructive stability substantiate
 tolerate(s)

Writing SOAP Notes

(taken (with additions) from *Learning to Write Case Notes Using the SOAP Format* –Susan Cameron and Imani turtle-song)

SOAP notes were developed in 1964 by L.L.Weed to enhance continuity of client care and assist in better recall/communication of details between and for the healthcare professional. Other case notes that are variations of the SOAP note model include:

DAP – Data, Assessment, Plan FOR – Functional Outcomes Reporting

Using the SOAP Format

The four components of SOAP notes are:

- (S) subjective
- (O) objective
- (A) assessment
- (P) plan

S – Subjective information about the presenting problem from the **client's** perspective.

O – Objective information observed by the **counselor**.

A – Assessment that demonstrates how the S and O data is **formulated/interpreted/reflected upon**.

P – plan summarizing of the **direction of treatment**.

Subjective

This section can be the most troublesome. Here the client's feelings, goals and thoughts as well as the intensity of the problem and how it may affect significant other(s) are recorded. The entry should be as **brief and concise** as possible without the overuse of quotations since at the end of a session, research shows that it is unlikely to accurately remember verbatim information. If, however quotations are used, only key words or phrases should be recorded. For example, this might include a suicidal or homicidal ideation, unwillingness to provide necessary information, inappropriately aggressive or abusive language that the counselor may deem threatening.

For instance, a father accused of shaking his 6-month-old daughter when she would not stop crying says, "I only scared her when I shook her, I didn't hurt her."

*The counselor might write: "Minimizes the effects of shaking infant daughter. States, "I only scared her." **Use only a minimum of quotes***

Ways to write briefly, **yet concisely**:

The client may say, "Therapy is really helping me put my life into perspective," (10 words), could be written "Reports therapy is really helping." (Five words)

Rather than using names of specific people's names, use general terms as "fellow employee" or "mental health worker", and briefly report the **themes** of the client's complaint.

The content of the **S** section belong to the client. For brevity's sakes, the counselor should write, "reports, states, says, describes, indicates, complains of.

For example, instead of writing, "Today the client says, 'I am experiencing much more marital trouble since the time before our last session' (14 words), the counselor might write, "Client reports increased marital problem since last session." (8 words).

Objective

This information should be factual and in quantifiable terms – that which can be seen, heard, smelled, counted or measured. Avoid words such as "appeared" or "seemed" without objective supporting evidence. Avoid labels, personal judgments, opinionated statements. Words that carry a negative connotation such as, "uncooperative", "manipulative," "abusive," "obnoxious," "spoiled," "dysfunctional," and "drunk." These words are open to personal interpretation. The most helpful phrase is, "as evidenced by."

For example, “Appeared depressed, as evidenced by significantly less verbal exchange; intermittent difficulty tracking. Hair uncombed, clothes unkept. Denies feeling depressed.”

Simply record what is seen, heard, or smelled.

For example, “Client smelled of alcohol; speech slow and deliberate in nature; uncontrollable giggles even after stumbling against door jam; unsteady gait.”

Assessment

This section summarizes the counselor’s **clinical thinking**. Clinical impressions may also be used to “rule out” or “rule in” a diagnosis. Clinical impressions also enable viewers to follow the counselor’s reasoning and direction for treatment. When making a diagnostic impression, ask the question, “Is there adequate/sufficient data here to support a clinical diagnosis?” If sufficient data has been collected, the **S** and **O** sections should reasonably support the diagnosis. If, however, there is ambivalence in making a diagnosis this might suggest insufficient data has been collected or that a consultation with a senior colleague is in order.

Plan

This section describes the parameters of the intervention. It consists generally of two parts, the action plan and the prognosis. It may include a referral to an agency or some other form of intervention. The prognosis is a forecast of the probable gains to be made by the plan.

Scenario

Cecil is a 34-year-old man who was mandated by the courts to obtain counseling to resolve his problems with domestic violence. He comes into the office, slams the door, and announces in a loud and irritated voice, “This counseling stuff is crap! There’s no parking! My wife and kids are gone! And I gotta pay for something that don’t work!”

Through most of the counseling session Cecil remains agitated. Speaking in an angry and aggressive voice, he tells you that his probation officer told him he was a good man and could get his wife and kids back. He demands to know why you are not really helping him get back what is the most important to him. He insists that, “Mary just screws everything up?” He goes on to tell you of a violent argument he and Mary had last night regarding the privileges of their daughter Nicole, who just turned 16. You are aware that there is a restraining order against Cecil.

During the session, you learn Cecil was raised in a physically and verbally abuse family until he was 11, at which time he was placed in protective custody by social services, where he remained until he was 18. He goes on to tell you that he has been arrested numerous times for “brawling” and reports that sometimes the littlest things make him angry and he just explodes, hitting whatever is available – the walls, his wife, the kids, and three guys at work. Cecil also

reports prior arrests for domestic violence. He admits that at various time, he has been both physical and emotionally abusive to Mary and the children but insists that it was needed to "straighten them out." Just before leaving your office, Cecil rushes from his chair and stands within a foot of you. Angrily, with his fist and jaw clenched, he says, "This is the same old B.S. You guys are just all talk." He storms from the room.

Sample SOAP note (using abbreviations and *meanings* not put in above notes)

S: Reports csIng (counseling) not helpful in getting family back. Insists on violence to "straighten out" family. Reports hx (history) of DV(Domestic violence). States verbally fought & (with) wife over oldest child's privileges. Clt. or C (circled) reported personal physical and mental abuse as child resulting foster care placement, ages 8-11.

O: Generally agitated in session as evidenced by clenched fist and jaw. Near end of session, clt or C(circled) stated counseling is "same old B.S!" Rushed out of office.

A: Physical abuse as adult and child.

P: Prognosis guarded due to ↓(decreases or low) level of motivation to change. Will continue _____therapy. Possible referral to Dr. _____ for psych. (psychiatric) eval.(evaluation) and Men's Alternative Violence Group. Next session, introduce use of "time outs."