

Neurology SOAP note example

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A fictional neurology SOAP note example that documents symptom pattern, focused examination, uncertainty, clinical reasoning, and patient-specific follow-up without prefilled normal findings.

Clinical boundary

This example is not a headache protocol, emergency screen, neurological examination standard, diagnostic rule, or treatment recommendation. Acute or changing neurological symptoms require patient-specific assessment.

Fictional SOAP example

Subjective

Fictional adult patient reports episodic headaches with a similar location and quality to prior events, occurring twice during the past month. The patient reports light sensitivity and improvement after rest.

No new weakness, speech change, loss of consciousness, fever, head injury, or persistent visual change is reported in this example. The clinician still determines which warning features require direct assessment.

Objective

Vital signs and the focused neurological examination are documented from today's encounter. The note records mental status, cranial nerve, motor, sensory, coordination, and gait findings only for modules actually examined.

Laterality, technique, grading scale, baseline, and examination limitations are recorded where they affect interpretation.

Assessment

Recurrent episodic headache with features similar to the previously documented pattern. No new focal symptom is reported and no new focal finding is documented in the examined modules of this fictional encounter.

The working impression remains provisional. The assessment should state whether the pattern, frequency, severity, examination, comorbidity, or available data changed the clinician's level of concern.

Plan

Document the clinician's patient-specific investigation, medication, counselling, monitoring, follow-up, and return-precaution decisions.

If a diary, test, referral, or outside record is used, record what is being tracked, who reviews it, and what finding should prompt earlier reassessment.

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Headache pattern, frequency, and functional impact

Associated symptoms and relevant warning features

Medicines, exposures, and prior evaluation

Focused neurological examination modules

Technique, laterality, grading, and limitations

Pattern comparison and working impression

Meaningful uncertainty

Monitoring, results ownership, follow-up, and contingencies

Review checklist

- Change from the established symptom pattern
- Exam modules performed and their limitations
- Laterality, grading, and baseline comparison
- Ownership of pending tests, diaries, referrals, and follow-up

Sources consulted

NCBI Bookshelf, SOAP Notes: <https://www.ncbi.nlm.nih.gov/books/NBK482263/>

AAFP, Writing Clinical Notes: Have We Made Progress?: <https://www.aafp.org/fpm/2022/0700/writing-clinical-notes>

Stanford Medicine 25, Neurology Exam Guides: <https://stanfordmedicine25.stanford.edu/exam-guides-.html>

Merck Manual Professional, Approach to the Neurologic Patient: <https://www.merckmanuals.com/professional/neurologic-disorders/approach-to-the-neurologic-patient/approach-to-the-neurologic-patient>