MENTALYC

5 SOAP Note Examples

Real-format mental health progress notes you can copy and adapt

For licensed clinicians

INSIDE THIS PACK

01	SOAP Note: Depressed Mood	Adult, individual
02	SOAP Note: Anxiety Symptoms	Child, individual
03	SOAP Note: Couple Therapy	Communication, intimacy
04	SOAP Note: Family Communication	Parents + adolescent
05	Intake Note: Anxiety Symptoms	New client, initial assessment

All sample notes are fictional and not derived from real sessions. Source: mentalyc.com/note-examples.
Adapt language to your clinical voice, your jurisdiction, and your documentation standards.

© 2026 Mentalyc Inc. · mentalyc.com

SOAP Note: Depressed Mood

ADULT MDD FEATURES CBT + IPT

S SUBJECTIVE · CLIENT'S SELF-REPORTED SYMPTOMS AND CONCERNS

Presentation

Chief Complaint: The client presented with a depressed mood, low motivation, loneliness, and difficulty connecting with others.

> *"I don't know, some days I'm just feeling horrible."*

Impairments and Challenges: The client described impairments in motivation, engagement in previously enjoyed activities like making music, and establishing meaningful relationships. Their isolation and loneliness appeared to exacerbate their depression.

> *"I just feel so miserable."*

Psychological Factors

Symptom 1:

- **Description:** Depressed mood most of the day, nearly every day.
- **Onset:** Ongoing, no specific onset provided.
- **Frequency:** Daily.
- **Ascendance:** No improvements reported.
- **Intensity:** Moderate to severe.
- **Duration:** Several years per client report.

> *"I'm always seeing things I know I can't do. It feels heavy."*

Symptom 2:

- **Description:** Low motivation and withdrawal from previously enjoyable activities.
- **Onset:** Gradual, no specific onset provided.
- **Frequency:** Daily.
- **Ascendance:** No improvements reported.
- **Intensity:** Moderate to severe lack of motivation.
- **Duration:** Several years per client report.

> *"I just go places where there's no one and sit there alone."*

O OBJECTIVE

Clinical Assessment

Assessment Tool: Clinical Interview

Results: Read above.

Status: Ongoing.

Risk Assessment

Risks or Safety Concerns: No risks or safety concerns identified.

Interventions

Therapeutic Approach or Modality: Cognitive-behavioral therapy, interpersonal therapy.

Psychological Interventions:

- Validated feelings.
- Encouraged challenge of automatic thoughts.
- Assigned thought tracking.

Rationale: Increase awareness of cognitive distortions fueling depression. Begin the process of identifying and challenging automatic negative thoughts.

A ASSESSMENT · PROGRESS AND RESPONSE

Response to Treatment: The client displayed limited engagement and motivation for change.

Specific Examples: Client keeps deflecting from talking about certain issues.

> *"I don't know, I don't think I can."*

Challenges to Progress: Lack of motivation and avoidance of social connections will likely impede progress. Negative automatic thoughts and cognitive distortions will also pose a challenge.

Therapist Observations: Client is fused with their negative thoughts; may need to introduce defusion techniques.

Therapeutic Alliance: The client showed some resistance. She was hesitant to talk about certain things related to her anxiety. The therapist processed that with her.

P PLAN · FOLLOW-UP ACTIONS AND PLANS

Homework: Complete thought records identifying automatic negative thoughts and labeling cognitive distortions. Engage in one social activity.

Plan for Future Session: Review thought records, continue cultivating motivation and self-efficacy, begin discussing behavioral activation steps.

Plans for Continued Treatment: Continue weekly therapy, consider psychiatric referral if lack of progress.

Coordination of Care: No coordination of care indicated at this time.

Source: mentalyc.com/note-examples/example-soap

© Mentalyc Inc. · Fictional example, for educational use

Generate SOAP notes with AI →

SOAP Note: Anxiety Symptoms

CHILD, 11 Y/O GENERALIZED ANXIETY CBT

S SUBJECTIVE · PRESENTATION

Chief Complaint: Client, an 11-year-old female, presented for her fifth therapy session. Continues to endorse anxiety symptoms including worry, difficulty sleeping, and avoidance behaviors.

> *"I'm still worried about a lot of things and having trouble sleeping most nights."*

Impairments and Challenges: Client reports anxiety continues to impair concentration at school; academic performance has not improved. Anxiety prevents participation in social activities and sleepovers. Ongoing irritability and low frustration tolerance due to lack of sleep noted.

> *"It's so hard to focus on schoolwork when I'm worried. I don't want to hang out with friends because I just want to go home."*

Psychological Factors

Symptom 1:

- **Description:** Excessive general anxiety, uncontrollable worry, rumination.
- **Onset:** 6 months ago.
- **Frequency:** Daily.
- **Ascendance:** Minimal improvement in worry.
- **Intensity:** Severe.
- **Duration:** Persistent, 6 months.

> *"I can't stop worrying all the time no matter what I try."*

Symptom 2:

- **Description:** Insomnia, difficulty falling asleep and staying asleep most nights.
- **Onset:** 6 months ago.
- **Frequency:** 5–6 nights per week.
- **Ascendance:** No improvement in sleep difficulties reported.
- **Intensity:** Moderate.
- **Duration:** Persistent, 6 months.

> *"I toss and turn for hours before I can fall asleep and then I'm tired all day."*

O OBJECTIVE

Clinical Assessment

Assessment Tool: Clinical Interview.

Results: Client continues to report severe anxiety and worry across settings. Sleep remains disturbed most nights. Avoidance behaviors limit social activities. Psychoeducation and early CBT skills have resulted in minimal symptom reduction to date.

Status: Will administer SCARED assessment for anxiety at next session for further evaluation.

Risk Assessment

Risks or Safety Concerns: No risks or safety concerns noted during session. Client denies suicidal ideation or self-harm. No homicidal ideation evident.

Interventions

Therapeutic Approach or Modality: CBT interventions focused on identifying and challenging anxious automatic thoughts.

Psychological Interventions:

- Assigned thought records for homework.
- Modeled modifying anxious thoughts through Socratic questioning.
- Practiced cognitive restructuring skill during session.

Rationale: Cognitive restructuring aimed at teaching client to identify and replace anxious thinking patterns with more balanced thoughts.

A ASSESSMENT · PROGRESS AND RESPONSE

Response to Treatment: Client has been engaged in therapy process but still struggles with consistent application of CBT skills outside of sessions. Minimal reduction in target symptoms to date.

Specific Examples: Completed thought records inconsistently since last session. Participated willingly in cognitive restructuring exercise during session but had difficulty generating alternative thoughts independently.

> *"I'm trying to use the thought records, but it's hard to remember. I still feel worried all the time."*

Challenges to Progress: Client struggles with utilizing CBT skills consistently outside of therapy sessions. Continued anxiety symptoms interfere with concentration needed to implement CBT techniques.

Therapist Observations: Client has grasped CBT concepts but minimal progress may signify need to adjust therapeutic approach to better meet client's needs. Will consult with parents for additional insight into symptoms and functioning at home and school.

Therapeutic Alliance: Client was engaged in session with good rapport. No ruptures in therapeutic relationship noted.

P PLAN · FOLLOW-UP ACTIONS AND PLANS

Homework: Complete daily thought records. Challenge anxious thoughts using skills practiced in session.

Plan for Future Session: Administer SCARED assessment of anxiety. Adjust CBT approach as needed. Increase parental involvement.

Plans for Continued Treatment: Continue weekly 50-minute CBT sessions.

Coordination of Care: Parent reports speaking regularly with pediatrician who made referral. Will consult with pediatrician and parents for additional recommendations to enhance progress.

Source: mentalyc.com/note-examples/example-soap-7e37e

© Mentalyc Inc. · Fictional example, for educational use

Generate SOAP notes with AI →

SOAP Note: Couple Therapy

COUPLE | COMMUNICATION, TRUST, INTIMACY | CBT + GOTTMAN

S SUBJECTIVE · PRESENTATION

Chief Complaint: Couple presented for their fifth therapy session, continuing to report issues related to communication, trust, and rebuilding intimacy in the marriage.

> *"We still struggle sometimes to communicate openly." — Wife*

Impairments and Challenges: Despite recent progress, clients continue to experience relationship tension, arguments, and difficulty maintaining emotional intimacy. Lack of trust and resentment remain problematic.

> *"I can't fully open up when I know she's still holding onto resentment." — Husband*

Communication Patterns: Communication has improved with more empathy and validation. However, some key issues remain unresolved, leading to avoidance of discussing certain topics.

> *"We communicate better in general but avoid the deeper issues." — Wife*

Conflict Resolution: Clients report using skills to de-escalate conflicts when they arise. However, core relationship wounds have not been healed, leading to unresolved arguments at times.

> *"We can calm things down when we fight but still feel hurt afterwards." — Husband*

Psychological Factors

Symptom 1:

- **Description:** Trust issues, insecurity, and jealousy continue in the relationship.
- **Onset:** 1 year ago.
- **Frequency:** 2–3 times per week.
- **Ascendance:** Minimal improvement.
- **Intensity:** Moderate.
- **Duration:** Persistent over past year.

> *"I still sometimes worry he's not telling me everything." — Wife*

Symptom 2:

- **Description:** Rebuilding emotional and sexual intimacy remains a challenge.
- **Onset:** 8 months ago.
- **Frequency:** Ongoing issue.
- **Ascendance:** Some minor improvement in emotional intimacy.
- **Intensity:** Significant.
- **Duration:** 8 months.

> *"It's hard for us to reconnect physically when we still feel distant." — Husband*

O OBJECTIVE

Clinical Assessment

Assessment Tool: No new assessments administered.

Results: N/A.

Status: Initial clinical interview and assessment remain sufficient currently. Additional tools may be considered if progress stalls.

Risk Assessment

Risks or Safety Concerns: No risks or safety concerns expressed during the session by either party.

Interventions

Therapeutic Approach or Modality: Continued use of CBT and Gottman techniques focused on improving communication, empathy, and conflict resolution.

Psychological Interventions:

- Practiced speaker/listener technique.
- Discussed identifying negative sentiment override.
- Assigned reading on rebuilding trust after conflicts.

Rationale: Interventions targeted at improving emotional attunement, empathy, and progressing through relationship injury impasses.

A ASSESSMENT · PROGRESS AND RESPONSE

Response to Treatment: Clients report some progress with communication and conflict resolution skills. However, core relationship intimacy issues remain. Resistance to vulnerability present at times.

Specific Examples: Each partner took turns speaking and listening during exercise. Wife had difficulty accepting husband's perspective.

> *"I think we communicate better, but we need to keep working on fully reconnecting." — Husband*

Challenges to Progress: Lingering resentment, lack of trust, and avoidance of emotional intimacy remain barriers. Resistance to vulnerability is impeding progress.

Therapist Observations: Despite skills practice, core wounds remain unaddressed. Therapist observed lingering hostility from wife towards husband. Individual work may be needed to complement couples treatment.

Therapeutic Alliance: Alliance remains strong with both clients, who are engaged in the therapeutic process.

P PLAN · FOLLOW-UP ACTIONS AND PLANS

Homework: Practice speaker/listener technique at home. Complete assigned reading.

Plan for Future Session: Process lingering relationship injuries. Assess need for individual sessions to complement couples work.

Plans for Continued Treatment: Continue weekly couples joint sessions. Consider adding periodic individual sessions as needed.

Coordination of Care: No coordination of care needs at this time.

Source: mentalyc.com/note-examples/example-soap-b6a6c

© Mentalyc Inc. · Fictional example, for educational use

Generate SOAP notes with AI →

SOAP Note: Family Communication

FAMILY CONFLICT, COMMUNICATION CBT + PARENT ED

S SUBJECTIVE · PRESENTATION

Chief Complaint: The family reported ongoing issues with communication breakdowns and arguments. However, the frequency and intensity of conflicts has reduced over the past month of therapy.

> *"We're still struggling to communicate calmly, but the big blowout fights have gone down." — Father*

Impairments and Challenges: The parents state arguments disrupt family functioning 1–2 times per week. The daughter continues to isolate herself when upset.

> *"The arguments make me really anxious and then I just go to my room to get away from it." — Daughter*

Communication Patterns: Family members listen better but still frequently interrupt or talk over each other when emotions escalate.

> *"We'll be calm at first but then we all start raising our voices and no one hears what the other is saying." — Mother*

Conflict Resolution: Family has improved ability to de-escalate from arguments, but continue to struggle resolving core issues.

> *"We've gotten better at taking a time out when tensions rise, but we need help solving our disagreements once we cool down." — Father*

Family Dynamics: Parents are more involved in daughter's life but she continues keeping some feelings private.

> *"We've been trying to do more together as a family, but sometimes it still feels like she shuts us out." — Mother*

Family Roles: Parents allowing daughter more autonomy but still revert to overcontrol at times. Daughter becoming more responsible.

> *"They've lightened up on the rules some, but then they'll crack down again over every little thing." — Daughter*

Family Rules and Boundaries: Family has negotiated some rules to allow daughter more age-appropriate independence. Some ongoing tensions around curfew.

> *"I know they worry, but I wish my curfew could be later like my friends'." — Daughter*

O OBJECTIVE

Clinical Assessment

Assessment Tool: Family Communication Scale, Session Check-In Form.

Results: Family's average communication score improved from 2.3 to 3.1 out of 5 over past month of treatment. Daughter's session engagement increased from 3 to 4 out of 5.

Status: Assessments will continue weekly to track progress on goals.

Interventions

Therapeutic Approach or Modality: Cognitive-behavioral, Communication Skill Building, Parent Education.

Psychological Interventions:

- Practiced reflective listening during enactment.
- Discussed balancing teenage autonomy and parental authority.
- Assigned homework practicing "I feel" statements.

Rationale: Interventions targeted improving family communication and adjusting family roles and rules to support healthy adolescent development.

A ASSESSMENT · PROGRESS AND RESPONSE

Response to Treatment: Family has shown good compliance with treatment. Communication slowly improving.

Specific Examples: Family's average communication score has increased over the past month.

> *"I feel like we're starting to understand each other better." — Daughter*

Challenges to Progress: Family still struggles with emotional escalation and talking over each other. Core issues remain unresolved.

Therapist Observations: Family is slowly building insight and skills but needs more work resolving underlying sources of conflict.

Therapeutic Alliance: Alliance with daughter remains tentative at times. Will continue efforts to strengthen.

P PLAN · FOLLOW-UP ACTIONS AND PLANS

Homework: Practice "I feel" statements during family discussions. Continue communication scale ratings.
Plan for Future Session: Next session will focus on identifying core family conflicts and practicing conflict resolution skills.
Plans for Continued Treatment: Family will continue weekly sessions with reassessment in 4 weeks.
Coordination of Care: No current coordination of care indicated.

Source: mentalyc.com/note-examples/example-soap-3ecbd

© Mentalyc Inc. · Fictional example, for educational use

Generate SOAP notes with AI →

Intake Note: Anxiety Symptoms

ADULT, INITIAL | GAD + PANIC | CBT, CFT, EMDR (PLANNED)

Session Title

Initial Assessment to Explore Anxiety Symptoms and Challenges.

Brief Summary

The client presented with anxiety symptoms that have been ongoing for 7–8 years, including panic attacks, health-related fears, and social anxiety. She described difficulty publicly speaking, discomfort in groups, obsessive thoughts, and impairments in work, school, and relationships. The therapist conducted a clinical interview, gathered background information, made initial diagnoses of generalized anxiety disorder with panic, and developed a preliminary treatment plan involving CBT, compassion-focused therapy, EMDR, and polyvagal theory approaches.

Consent

The therapist reviewed confidentiality, limits of confidentiality around harm to self or others, payment procedures, and the client's rights. The client seemed to understand and agree to informed consent, asking clarifying questions.

> *"I feel comfortable proceeding with treatment."*

S SUBJECTIVE · PRESENTATION

Chief Complaint: The client presented with ongoing anxiety symptoms that she feels are getting worse, including panic attacks, health-related fears, social anxiety, and discomfort being in groups. She described anxiety being very prominent in her life for the past 7–8 years.

> *"My anxiety feels like a dark cloud over me every single day, making it hard to function or find joy in life."*

Impairments and Challenges: The client's anxiety causes impairments in work, school, parenting, relationships, and social functioning. She has panic attacks during public speaking, group meetings, and in other anxiety-provoking situations. She has withdrawn socially and become more quiet around groups due to social anxiety.

> *"Whenever I feel anxious at work, it's like my mind goes blank and I can't get anything done."*

Psychological Factors

Family Mental Health History: The client did not disclose any significant family mental health history.

Previous Mental Health Treatments: The client saw a therapist previously for about a year and a half who provided hypnotherapy to help her take medications she had developed a phobia towards. She felt she was not getting what she wanted from that therapy.

Previous Mental Health Assessments: No previous diagnostic testing or psychological assessments were noted.

Symptom 1: Panic attacks

- Onset: First panic attack occurred around age 18.
- Frequency: Used to occur about once per week, now less frequent (last one was 6 months ago).
- Ascendance: Becoming much less frequent than they used to be.
- Intensity: Very severe when they do occur.
- Duration: On and off for about 7–8 years.

> *"During a panic attack it feels like I'm dying — my heart races, I sweat, and I lose control completely."*

Symptom 2: Health-related anxiety

- Onset: Started around age 18 after a negative experience taking a new medication.
- Frequency: Occurs frequently when she has medical appointments, takes medication, or notices physical symptoms.
- Ascendance: No improvement described.
- Intensity: Very severe.
- Duration: Present for around 7–8 years.

> *"Whenever I have a doctor's appointment I obsess for days beforehand about all the worst case scenarios."*

Symptom 3: Social anxiety

- Onset: Started more recently in the past 1–2 years.
- Frequency: Occurs frequently when in groups or social situations.
- Ascendance: No improvement, feels it has gotten worse.
- Intensity: Severe and very uncomfortable when it occurs.
- Duration: Present for around 1–2 years.

> *"Being in a big crowd makes me want to crawl out of my skin — it's complete torture."*

Symptom 4: Depressed mood

- Onset: Started in the past year.
- Frequency: Frequent over the past year.
- Ascendance: No improvement described.
- Intensity: Did not specify severity.
- Duration: Present for around 1 year.

> *"This heaviness and sadness comes over me and it's hard to remember what it feels like to be light and happy."*

Biological Factors

Medications: None reported. Allergies: None reported. Family medical history: None significant. Medical conditions: Client believes she may have high blood pressure which she associates with anxiety. Sleep, nutrition, physical activity, sexual activity: no issues reported. Substances: Reported experimenting with drugs during college, including a severe panic attack after an unspecified drug. No current or regular substance use.

Social Factors

Work or School: Works in insurance sales on a team of all men. Has struggled to find satisfying work since graduating college and has changed jobs frequently. Uncertain she likes her current job and lacks passion for it. Feels she has to monitor her behavior around male coworkers.

Relationships: Lives at home and has been with her boyfriend for 1.5 years. Describes some challenges due to his mood swings but feels generally happy. Feels she has suppressed her personality to avoid conflict. Family relationships are close and supportive.

Family Social History: Described a close family growing up and positive friendships. Had a rebellious period as a teenager due to strict parents. Now has a good relationship with her parents again.

Traumatic Experiences: Reported losing a close friend at age 18 which affected her, but she did not describe lasting trauma symptoms from this loss.

> *"Although losing my friend affected me deeply, I was able to get through the grieving process and don't feel traumatized presently."*

O OBJECTIVE

Clinical Assessment

Clinical Conceptualization: The client appears to have developed generalized anxiety disorder with panic attacks following some early losses and traumas around age 18. Her tendency to avoid and mask symptoms has perpetuated the anxiety, while trying to overly control her life has caused impairments. There are signs of comorbid depression emerging in the past year, likely due to chronic anxiety. Social and performance anxiety also appear tied to hypervigilance and poor distress tolerance.

Diagnosis 1: Generalized Anxiety Disorder

- DSM-5 Code: 300.02
- ICD-10 Code: F41.1
- Reasoning: The client exhibits excessive anxiety and worry across multiple domains that is difficult to control, including restlessness, fatigue, concentration issues, muscle tension, and sleep disturbance. Symptoms have persisted longer than 6 months and cause significant distress or impairment.

Diagnosis 2: Panic Disorder

- DSM-5 Code: 300.01
- ICD-10 Code: F41.0
- Reasoning: The client has experienced recurrent, unexpected panic attacks followed by at least 1 month of persistent concern about additional attacks or maladaptive changes in behavior related to the attacks.

Comorbidity: The client likely has comorbid social anxiety disorder given her severe anxiety and avoidance of social situations and public speaking. Depressive disorder is also a probable comorbidity based on her descriptions of depressed mood, low motivation, and feelings of worthlessness in the past year.

Assessment Tool: Clinical Interview.

Status: Additional diagnostic assessments may be warranted to confirm diagnoses and inform treatment planning.

Mental Status Exam

- **Mood and Affect:** Anxious mood, affect is congruent.
- **Speech and Language:** Clear, coherent, normal in rate and tone.
- **Thought Process and Content:** Logical and goal-directed. Focused on anxiety and panic symptoms. No evidence of delusions or obsessions.
- **Orientation:** Oriented to person, place, and time.
- **Perceptual Disturbances:** None reported or observed.
- **Cognition:** Appears intact based on interview.
- **Insight:** Demonstrates insight into her diagnosis and need for treatment.

Risk Assessment

No safety concerns or risks reported, stated, implied, or observed. No hopelessness. No suicidal thoughts, plans, or intent. No self-harming behaviors. Not dangerous to others.

> *"I am not having any thoughts of hurting myself or others. I feel safe and stable at this time."*

Safety Plan: No safety plan was indicated or developed during this initial session.

Strengths and Resources

Internal Strengths: Demonstrated self-awareness and willingness to seek help. Motivation to overcome her anxiety struggles.

External Resources: Close family relationships and a supportive boyfriend.

> *"I'm ready to put in the hard work to get better — I know I have strengths that will help me through this process."*

Interventions

Therapeutic Approach or Modality: Cognitive behavioral therapy, compassion-focused therapy, and EMDR approaches were proposed as appropriate modalities to address the client's anxiety.

Psychological Interventions:

- Clinical interview to gather background information.
- Psychoeducation about anxiety disorders.
- Introduction of possible treatment approaches.
- Discussion of confidentiality and informed consent.

Rationale: Initial clinical interview and assessment to build rapport, gather information to formulate an initial diagnostic impression and treatment plan, ensure proper informed consent procedures, and introduce the client to potential therapeutic approaches.

A ASSESSMENT · PROGRESS AND RESPONSE

Response to Treatment: Initial intake session; no formal treatment has started yet. The client seemed open and responsive during the interview process.

Specific Examples: The client asked questions to understand more about the process.

> *"I feel better just coming in today."*

Therapist Observations: The client exhibits significant anxiety affecting multiple areas of functioning. She lacks coping skills to manage anxiety effectively. Initial rapport was established during this intake session.

Therapeutic Alliance: Strong initial rapport established. No alliance issues noted.

Discussed Goals

Goal 1: Better understand and manage anxiety symptoms.

- Metrics: Reduce panic attack frequency and self-reported anxiety levels.
- Attainability: With client motivation and consistent practice of CBT and mindfulness techniques.
- Relevance: Highly relevant to improving client's quality of life and functioning.
- Timeframe: Expect regular progress over 8–12 weeks.

> *"The anxiety has such a grip on my life right now. I'll know I'm better when I break free from its constant presence."*

Goal 2: Improve ability to speak up for needs and set boundaries.

- Metrics: Increase assertive responses during role plays and real-life situations. Reduce people-pleasing behaviors.
- Attainability: Through self-compassion exercises, assertiveness training, and cognitive restructuring.
- Relevance: Important for managing anxiety, improving relationships, and boosting self-esteem.
- Timeframe: Expect gradual improvement over 8–12 weeks.

> *"I put too much pressure on myself to make others happy all the time. I need to learn how to put my needs first."*

Barriers to Achieving Goals: Lack of self-compassion, low distress tolerance, and avoidance behaviors may hinder progress if not addressed. Social anxiety also makes it difficult for her to speak up.

P PLAN · FOLLOW-UP ACTIONS AND PLANS

Homework: Complete initial assessments sent by the therapist and schedule next appointment.

Plan for Future Session: Begin compassion-focused therapy treatment plan, start Safe and Sound Protocol, and continue gathering assessment data.

Plans for Continued Treatment: Schedule weekly 50-minute sessions, with a week off in between, for 8–12 weeks initially.

Coordination of Care: No other providers involved currently. The therapist may coordinate with client's PCP in the future regarding anxiety treatment.

Source: mentalyc.com/note-examples/example-intake

© Mentalyc Inc. · Fictional example, for educational use

Generate intake notes with AI →