SOAP Notes, at a Glance

Four sections. One structured note. Use this beside your keyboard.

S — Subjective

What is the client telling you?

- Chief complaint in client's words
- History of present illness
- Symptom intensity, frequency, duration
- Relevant social, family, environmental context
- Direct quotes where they capture nuance

O — Objective

What are you observing?

- Appearance, hygiene, eye contact
- Behavior, motor activity, speech
- Affect, mood, congruence
- Assessment scores (GAD-7, PHQ-9, MSE)
- No interpretation, no opinions

A — Assessment

What is your clinical interpretation?

- Diagnosis or differential (DSM-5-TR, ICD-10)
- Severity and trajectory
- Contributing factors
- Risk indicators (SI, HI, self-harm)
- Tie back to specific S and O data

P — Plan

What happens next?

- SMART goals (Specific, Measurable, Achievable, Relevant, Time-bound)
- Interventions and modality
- Medications and changes
- Homework, referrals, follow-up cadence
- Safety plan if relevant

Do

- Be concise but thorough
- Use the client's exact words for emotional content
- Update the Assessment and Plan every visit
- Document risk and safety reasoning
- Sign and date the note

Don't

- Put opinions in the Objective section
- Use abbreviations others may not understand
- Cram multiple unrelated issues into one note
- Forget the "so what" — the clinical reasoning
- Neglect to note safety concerns when present

S: Client reports "I feel constantly on edge" and 4 panic attacks this week. 6-month history of worsening anxiety. Recent job loss.
O: Anxious, fidgety, avoids eye contact. Rapid speech. GAD-7 = 15 (moderate).
A: Generalized Anxiety Disorder (F41.1). Symptoms moderate, sleep disturbance secondary. No SI/HI.
P: Continue weekly CBT for 8 weeks. Goal: reduce panic from 4/week to 1/week within 12 weeks. Referral to psychiatry if no improvement by week 4.

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