Standard SOAP Template

S - Subjective

- Chief complaint:
- Patient-reported symptoms:
- Onset, duration, and frequency:
- Relevant medical/social history shared by the patient:
- Patient's perceived progress or concerns:

O - Objective

- Observations during session:
- Physical appearance/behavior:
- Speech patterns:
- Screening scores (PHQ-9, GAD-7, etc.):
- Clinical findings or measurable data:

A - Assessment

- Clinical interpretation of symptoms:
- Working diagnosis (if applicable):
- Progress since last visit:
- Response to current treatment:

P - Plan

- Interventions performed today:
- Recommended next steps:
- Medications prescribed or adjusted:
- Referrals (if any):
- Next appointment date:

SIGNATURES
• Clinician Name:
• Date:

Mental Health–Focused SOAP Template

S - Subjective

- Mood description (e.g., anxious, depressed, stable):
- Current emotional stressors:
- Sleep patterns, appetite, daily functioning:
- Suicidal ideation/self-harm thoughts (Yes/No):
- Patient's personal goals for mental health:

O - Objective

- Mental Status Exam (MSE):
- Appearance:
- Behavior:
- Speech:
- Thought process/content:
- Affect & mood:
- Insight & judgment:
- Risk assessment indicators:
- Relevant psychiatric test results:

A - Assessment

- Clinical summary of mental health condition:
- Diagnostic impressions (DSM-5 criteria):
- Symptom severity:
- Progress toward therapeutic goals:

P - Plan

- CBT/DBT/trauma-focused techniques planned:
- Safety plan (if required):
- Medication monitoring (psychiatric meds):
- Homework/exercises (journaling, grounding, tracking):
- Follow-up interval:

SIGNATURES
• Clinician Name:
• Date:

Counseling & Therapy SOAP Template

S - Subjective

- Client's narrative of current issues:
- Emotional themes discussed today:
- Relationship/work/school concerns:
- Client's motivation and engagement level:
- Updates on previous session assignments:

O - Objective

- Therapist observations of affect and behavior:
- Engagement during session:
- Body language and emotional expression:
- Notable cognitive or behavioral patterns:
- Therapeutic tools used today (e.g., role play, mindfulness):

A - Assessment

- Therapeutic interpretation of session content:
- Emotional or behavioral patterns observed:
- Client readiness for change:
- Progress on therapeutic goals:
- Barriers hindering improvement:

P - Plan

- Techniques to be used next session (e.g., CBT, narrative therapy):
- Assignments (journaling, communication tasks, worksheets):
- Areas of focus for upcoming sessions:
- Recommended external support (support groups, resources):
- Next session date/time:

SIGNATURES
• Clinician Name:
• Date: