SOAP Progress Note

Subjective • Objective • Assessment • Plan. One note per session, written promptly, specific enough that another clinician could continue care from it.

Client: _____ Date: _____ Time: _____

Clinician: _____ Session #: _____ Duration: _____ Setting: □ In person □ Telehealth

S Subjective

What the client reports: presenting concerns, symptoms in their words, changes since last session, homework report. Quote sparingly.

O Objective

What you observe or measure directly: appearance, behavior, affect, speech, mental status findings, attendance, measure scores (e.g., GAD-7, PHQ-9). Client statements never go here.

A Assessment

Your clinical interpretation: progress toward goals, patterns across sessions, risk status, working formulation. Use tentative language ("consistent with...").

P Plan

Next steps with owners and timeframes: interventions, homework, referrals, when you will reassess, date and focus of next session.

Signature / credentials

Date signed