SOAP Note Template

S SUBJECTIVE

In this section, record the client's concerns in their own words. This may include their mood, thought processes, motivation levels, sleep patterns and how they impact their day-to-day lives.

O OBJECTIVE

In this section, document the facts: signs, symptoms, and a mental state examination (appearance, behaviors, speech, mood, affect, thoughts, perception, cognition, insight and judgment).

A ASSESSMENT

In this section, include your formulation. This involves collating both objective and subjective information to form your impressions of the client's presentation, and where applicable, a diagnosis.

P PLAN

In this section, include your short-term and long-term goals for therapy.