SOAP Note Example for Anxiety

S SUBJECTIVE

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

Example: Since adopting a cat three months ago, the client reports experiencing frequent, intrusive, thoughts of contracting a viral infection. Soon after the adoption, she saw a news report about the risks of having a cat and has since been worried about becoming ill. She reports washing her hands frequently and having up to four showers per day. She says her hands are dry, cracked, and at times, bleed, due to the harsh soaps she uses.

The client reports she adopted the cat during a stressful time in her life, following the death of her maternal grandmother, whom she was reportedly close with.

She says she "knows" the fear is irrational, but the thoughts won't go away, and the only way to alleviate the anxiety, momentarily, is to engage in a cleaning ritual.

The client says she works from home, so the behavior does not interfere with her work, but her partner and family have been worried about her. They are also frustrated by her concerns and try to reassure her that it will be okay. She says it is unhelpful when they suggest she rehome the cat as she really loves her cat, but the fear of becoming ill means she does not get to "enjoy" her pet as much as she would like.

She reports experiencing insomnia due to excessive worrying about becoming ill, often staying up late researching symptoms and signs. She gets, on average; four hours of sleep per night.

In retrospect, she says she has always been anxious about hygiene and cleanliness and recalls washing her hands frequently as a child, resulting in dry peeling skin.

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).

Example: The client is a 27-year-old woman, dressed in casual clothing.

She rubbed her hands together and picked at her cuticles during the session. Her speech, at times, was pressured, and the content of her worries was related to her cat and health concerns.

The client reports poor sleep and appetite.

The client reports a family history of anxiety: her mother was diagnosed with OCD, and her sister has generalized anxiety disorder. The client has a possible history of OCD symptoms in childhood.

The client denies thoughts of self-harm or suicide.

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.

Example: The client's symptoms are consistent with obsessive-compulsive disorder (OCD). She experiences frequent, unwanted and distressing thoughts about contracting an illness from her cat. The intrusive thoughts are followed by the compulsion to rid herself of germs by excessive hand washing and cleaning. There is marked anxiety present.

She has a possible childhood history of OCD symptoms and a family history of anxiety disorders. This current episode was triggered after two major life events: the death of her maternal grandmother and adopting a cat.

The anxiety impacts her daily functioning, relationships and her health (dry, cracked and bleeding hands).

- **Diagnosis:** Symptoms suggestive of obsessive-compulsive disorder.
- **Differential diagnosis:** Possible generalized anxiety disorder or acute grief reaction.

P PLAN

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

Example:

- **Immediate:** Begin cognitive behavioral therapy for OCD. Schedule weekly sessions.
- **Follow-Up:** Review progress after six sessions.