SOAP Note Template

Client Name: _____ Date: _____

Session Type: _____ Clinician: _____

Diagnosis (if applicable): _____

Subjective

Describe the client's main concern or presenting problem.

Record the client's chief complaint using their own words when possible.

Note emotions, thoughts, or physical symptoms mentioned.

Add any details from family members or caregivers if relevant.

Objective

List vital signs and physical findings.

Record behaviors, appearance, and speech patterns.

Include eye contact, posture, and level of participation.

Mention results from clinical tests or assessments.

Assessment

Identify patterns based on subjective and objective information.

Note changes in client progress since the previous session.

Describe response to interventions or therapy session goals.

Include diagnostic impressions or relevant conditions.

Plan

Define goals for the next session or follow-up session.

List interventions such as relaxation techniques or mindfulness techniques.

Assign homework or self-care activities.

Record any specialist referral, additional testing, or necessary adjustments.

Indicate the date and focus of the upcoming session.

Clinician Signature: _____ Date: _____