SOAP note: counseling session

Client: [name or ID]

Date:

Session: [number, length in minutes, in person or video]

S: Subjective

Client's report: [main concern since the last session, in the client's words]

Symptoms and functioning: [mood, sleep, appetite, work, relationships]

Homework: [what was tried, how it went]

Risk: [thoughts of harming self or others, intent, plan, as asked and answered]

Substance use: [any change]

O: Objective

Appearance and behavior:

Mood and affect: [mood in the client's words, affect as observed]

Thought process and content:

Engagement in the session:

Measures: [questionnaire, score, compared with intake]

A: Assessment

Clinical impression: [progress, what keeps the problem going]

Risk assessment: [level and reasoning]

Progress toward treatment goals:

P: Plan

Interventions used today: [approach, technique]

Homework: [what the client agreed to try]

Next session: [date, focus]

Safety plan and crisis resources: [reviewed, updated, or not needed and why]

Referrals or coordination of care:

Sign-off

Signed: [name, credentials, date and time]