# Mental health SOAP note form, therapy session

Free template from soapnotes.xyz. Fill it in by hand or type over it.

## MENTAL HEALTH SOAP NOTE

Client _____

Date, start and end time _____

Session type _____

Clinician _____

Treatment plan goal addressed today _____

## S: SUBJECTIVE

Client's report, in their words (mood, main concern, events since last session):

Symptoms since last session (sleep, appetite, energy, anxiety, concentration):

Stressors and supports this week:

Medication taken as prescribed: [yes / no / not applicable], and any side effects reported:

Alcohol or other substance use since last session:

Thoughts of harming self: [ ] asked Answer:

Thoughts of harming others: [ ] asked Answer:

Progress on between-session tasks:

## O: OBJECTIVE

Appearance and behavior:

Speech:

Mood (reported) and affect (observed):

Thought process and content:

Orientation, attention and memory, if relevant:

Insight and judgment:

Engagement with the session:

Scores today (for example PHQ-9, GAD-7), with the last score:

Interventions used in session (name each, and what the client did):

Client's response to the interventions:

## A: ASSESSMENT

Progress toward the treatment plan goal (improving, no change, worse), with the evidence:

Clinical impression and any change in symptoms:

Risk (self, others, vulnerability) and what the risk level rests on:

Barriers to progress:

Diagnosis as documented in the record

## P: PLAN

Interventions for next session:

Between-session tasks for the client:

Frequency and date of next appointment:

Safety plan, referral or contact with other providers (as agreed with the client):

Change to the treatment plan: [ ] none [ ] yes, described

Signature and credentials:


Educational template, not medical or legal advice. Follow your employer and regulator rules.