Therapy progress notes cheat sheet

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

EVERY NOTE NEEDS

Client identifier (initials or record number, as your service requires)

Date, start and end time or session length

Session type: individual, couple, family or group; in person, phone or video

Who was present

Clinician name, credentials and signature

1. PRESENTATION

Mood in the client's words, in quotes

Affect, appearance and behavior you observed

Engagement: on time, engaged, guarded, distracted, left early

Phrases: "Arrived on time and engaged throughout." "Affect anxious, congruent with stated mood."

2. WHAT THE CLIENT REPORTED

Symptoms and changes since the last session

Key events, stressors and supports

Homework or between-session practice: done, partly done, not done, and why

Scores on any measures used, with the previous score

3. RISK

Record that you asked about thoughts of suicide, self-harm and harming others, and the answer

If risk is present: details, safety plan, consultation, actions taken

Phrase: "Asked about thoughts of suicide, self-harm and harming others. Denies all three."

4. INTERVENTIONS (what you did)

Start with a verb: explored, reflected, validated, taught, practiced, reframed, reviewed, role-played, assigned

Name the technique and what it targeted

Link it to a treatment plan goal

Phrase: "Taught paced breathing for panic symptoms (Goal 1)."

5. CLIENT RESPONSE

What the client did with it, in observable terms

Phrases: "Practiced the skill twice in session." "Identified two triggers." "Was receptive to..." "Struggled to..." "Declined..."

6. PROGRESS TOWARD GOALS

Rate it: progressing, maintaining, no change, regressed, goal met

Give the evidence: a score, a count, a behavior, the client's own words

7. PLAN

Next session date and frequency

Between-session work

Referrals, coordination and anything you will follow up

Changes to the treatment plan, and why

WORDS TO SWAP

"Seemed fine" -> describe mood, affect and what the client reported

"Good session" -> what was done and how the client responded

"Talked about stress" -> which stressor, what was explored, what changed

"Non-compliant" -> what did not happen and the reason given

"Refused" -> "declined", with the reason if known

CHECK BEFORE YOU SIGN

Could a colleague pick up the case from this note alone?

Does it link to at least one treatment plan goal?

Are facts and your interpretation easy to tell apart?

Is risk recorded, even when the answer was no?

Is detail about other people limited to what is needed?

Is it signed and dated within your service's time limit?

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