SOAP note: Subjective, Objective, Assessment, Plan

Common in: Most settings; integrated and medical teams. Write what you observed and did, link it to a treatment plan goal, and record the client's response.

Subjective

- Presenting concern or goal addressed today, in the client's words where useful
- Mood as the client reports it
- Relevant events since the last session, and homework follow-through

Objective

- What you observed: appearance, affect, behavior, engagement
- Measures given today: tool, date, total and band (for example PHQ-9 or GAD-7)
- Risk screen and result
- Session start and stop time, and service type or telehealth

Assessment

- Your clinical interpretation of today's findings
- Progress toward the treatment plan goal, with the trend in any score
- Why continued treatment is needed

Plan

- Interventions for the next session
- Homework, referrals or coordination
- Next appointment and when to repeat measures

Example (fictional): S: Client reports "a better week" and walked 3 mornings. O: Affect brighter, engaged; PHQ-9 total 12 (moderate), down from 16. A: Depressive symptoms easing with behavioral activation (Goal 1). P: Continue weekly; add a fourth activity; repeat PHQ-9 in 4 weeks.

DAP note: Data, Assessment, Plan

Common in: Outpatient counseling, quick notes. Write what you observed and did, link it to a treatment plan goal, and record the client's response.

Data

- What the client reported and what you observed, together
- Interventions you used and the client's response
- Measures given today and risk screen result
- Session start and stop time

Assessment

- Your interpretation of the data
- Progress toward treatment plan goals
- Why continued treatment is needed

Plan

- Next session focus and homework
- Referrals or coordination
- Next appointment

Example (fictional): D: Client described two panic episodes at work; practiced paced breathing in session and rated anxiety 4/10, down from 7. A: Client can use breathing to reduce anxiety in session; generalizing to work is the next step (Goal 2). P: Practice daily; review log next week.

BIRP note: Behavior, Intervention, Response, Plan

Common in: Behavioral health agencies. Write what you observed and did, link it to a treatment plan goal, and record the client's response.

Behavior

- Presenting behaviors and symptoms, observed and reported
- Mood and affect
- Risk screen and result

Intervention

- Named interventions and what each targeted
- Link to the treatment plan goal

Response

- How the client responded, in observable terms
- Skills demonstrated or scores obtained

Plan

- Next steps, homework and referrals
- Next appointment

Example (fictional): B: Client arrived tense, reported arguing with a parent twice this week. I: Role-played an I-statement script for conflict (Goal 1). R: Client rehearsed the script twice and identified one trigger. P: Use the script once before next session; review outcome.

GIRP note: Goal, Intervention, Response, Plan

Common in: Goal-driven treatment plans. Write what you observed and did, link it to a treatment plan goal, and record the client's response.

Goal

- The treatment plan goal or objective addressed today
- The client's own words about the goal, if useful

Intervention

- Named interventions used toward that goal

Response

- Client response and progress toward the goal
- Scores or observable change

Plan

- What happens next for this goal
- Homework and next appointment

Example (fictional): G: Reduce avoidance of social events (Objective 1b). I: Built an exposure ladder with the client. R: Client ranked 6 situations and chose a first step. P: Attend a 15-minute coffee meetup before next session.

PIE note: Problem, Intervention, Evaluation

Common in: Social work and case management. Write what you observed and did, link it to a treatment plan goal, and record the client's response.

Problem

- The problem addressed today, linked to the plan
- Relevant reported and observed information

Intervention

- What you did: services, referrals, coordination, interventions

Evaluation

- The client's response and progress
- What remains open and the next step

Example (fictional): P: Client at risk of losing housing after a missed rent payment. I: Completed an emergency rental assistance application with the client and called the landlord with consent. E: Application submitted; landlord agreed to wait 10 days. Follow up Friday.

Phrase bank and words to avoid

Intervention words

Pair each verb with a named technique and a target.

Explored · Processed · Validated · Reflected · Reframed · Challenged · Modeled · Role-played · Rehearsed · Taught · Provided psychoeducation on · Assigned · Reviewed · Facilitated · Assessed · Monitored

Client response words

Prefer what you observed or measured: "Rated anxiety 4/10, down from 7."

Identified · Demonstrated · Verbalized · Rated · Completed · Practiced · Agreed to · Declined · Was receptive to · Was unable to · Became tearful when · Reported · Initiated · Generated

Mood and affect words

Mood is what the client reports. Affect is what you observe.

Euthymic · Anxious · Dysphoric · Irritable · Restricted · Flat · Labile · Congruent with content · Tearful · Guarded · Engaged · Cooperative

Scores and measures

Tool, date, total and band, prior score. Example: "PHQ-9 completed 10/14, total 12 (moderate), down from 16 at intake; item 9 scored 0."

- Depression: PHQ-9 total 0 to 27, severity band, and item 9 on its own line. Guide: wellnotesai.com/resources/phq-9-scoring
- Anxiety: GAD-7 total 0 to 21 and severity band. Guide: wellnotesai.com/resources/gad-7-scoring
- PTSD symptoms: PCL-5 total 0 to 80 and the time frame used. Guide: wellnotesai.com/resources/pcl-5-scoring
- Suicide risk: C-SSRS version, answers that were positive, and the action taken. Guide: wellnotesai.com/resources/c-ssrs-documentation

Instead of this, write that

Instead of	Write something like (fictional)
"Provided support"	Validated the client's frustration about the job loss and reflected their wish to feel useful.
"Discussed feelings"	Explored grief about the move using an empty chair exercise.
"Client is doing better"	Client reports sleeping 6 hours most nights, up from 4; PHQ-9 total 12, down from 16.
"Client seemed depressed"	Affect restricted; client reports low mood "most days"; PHQ-9 total 14 (moderate).
"Client was manipulative"	Client asked twice to end early when homework was raised.
"Client was resistant or noncompliant"	Client declined the breathing exercise, said it "feels silly", and agreed to try a short walk instead.
"Session went well"	Client completed a thought record and named one alternative thought.
"Client is at risk"	Name the screen given, its result and the steps taken (for example, C-SSRS screener result and safety plan reviewed).

Medical necessity checklist

For Medicare claims, CMS says it can deny payment for incomplete or illegible records, and that documentation is insufficient when a reviewer cannot tell whether a service was provided, provided at the level billed, or medically necessary. Before you sign, check that:

- ☐ The record shows the service was actually provided.
- ☐ The record shows the service was provided at the level billed.
- ☐ The record shows why the service was medically necessary.
- ☐ The progress note has enough detail to show the service met coverage requirements.
- ☐ The record is legible and signed, including a supervising signature where one is required; an illegible signature needs a signature log or attestation.
- ☐ Any order, plan of care or form that Medicare or your payer's policy requires is present and complete.

Elements most progress notes carry

- ☐ Client identifier, date, start and stop time, service type and location (or telehealth)
- ☐ Why the client was seen: presenting concern or treatment goal addressed
- ☐ What you did: named interventions, not "provided support"
- ☐ How the client responded, with observable detail or a score
- ☐ Risk: what you screened for and the result, with any safety steps
- ☐ Progress toward treatment plan goals
- ☐ Plan: next session focus, homework, referrals, next appointment
- ☐ Your signature and credentials, completed within your required timeline

Progress notes vs psychotherapy notes

Keep private process analysis out of the progress note. Under HIPAA, psychotherapy notes are notes kept separate from the rest of the record, and the definition excludes medication prescription and monitoring, session start and stop times, the modalities and frequencies of treatment, results of clinical tests, and any summary of diagnosis, functional status, treatment plan, symptoms, prognosis and progress to date. Those belong in the progress note.

Sources

CMS MLN909160, Complying with Medical Record Documentation Requirements (December 2024): https://www.cms.gov/files/mln909160-complying-with-medical-record-documentation-requirements.pdf

45 CFR 164.501, definition of psychotherapy notes (govinfo.gov): https://www.govinfo.gov/content/pkg/CFR-2024-title45-vol2/xml/CFR-2024-title45-vol2-sec164-501.xml

This cheat sheet is general reference information, not clinical, billing, or legal advice. Documentation rules vary by payer, state and agency, so confirm requirements with your payer, supervisor and the official sources listed here. Example wording is fictional.