SOAP note

Subjective, Objective, Assessment, Plan

PATIENT	DATE OF SESSION
PROVIDER	MODALITY (E.G., CBT)
DIAGNOSIS (ICD-10)	CPT CODE

S — Subjective

Patient-reported symptoms, feelings, events since last session. First-person and self-report content.

O — Objective

Clinician-observed findings: mental status, affect, behavior, validated scale scores (PHQ-9, GAD-7).

A — Assessment

Clinical interpretation, diagnosis, progress toward treatment goals, risk status.

P — Plan

Interventions used, homework assigned, next appointment, any referrals or coordination of care.

PROVIDER SIGNATURE

DATE SIGNED