SOAP Method of Documentation

The SOAP method of documentation is one strategy for summarizing the important points of each visit or session. SOAP is an acronym for Subjective data, Objective data, Assessment and Plan for treatment. SOAP notes are just one method of documenting clinical services provided to clients. The major goal of this type of note is to outline clinical care or service in an analytical way (A) that is based on empirical data (S and O) leading to specific outcomes and plans (P).

The most difficult sections when writing clinical notes are the Subjective and Objective as it can sometimes be difficult to determine what constitutes subjective and objective content.

Subjective data is the information given by the client, or a responsible individual (i.e., foster parent) if the client is unable to speak for him or herself. How is the person doing? What is the client(s) perspective about the problem? What is the client’s opinion of the therapeutic intervention or service? This section can also be a place to document any information about the client given to you by someone else that you cannot verify but has an impact on the session or services. For example, a DCF worker reports that Susan recently lost her job. The subjective portion of the SOAP note contains information told to the provider/counselor, and can include direct quotations of clients such as, “these visits are really helping me to strengthen my parenting”.

Objective data is obtained during the interview with your client and includes such information as family background, referral reason, social context, etc. Objective data also includes any psychosocial information that is available at the time of writing down the progress notes (assessments, psychological testing, DCF referral or service plans, etc). It is information that your colleagues and supervisors would all agree on without much discussion. If an observer attended the session, what would she or he write? This is the section where you will report the measurable and observable information that you obtain during the session. For example, Susan engaged in age appropriate learning games with her daughter without any prompting from this provider. This is the section to report behaviors that you observe, not just the behaviors you are targeting. For example, you could report, “Steven repeatedly attempted to avoid interacting with his daughter as evidenced by his constant text messaging on his cell phone and he did not respond to her need for a diaper change”. There are two types of objective data: the provider’s observations and outside written materials. This is the section to document that which can be seen, hear, smelled, counted, or measured. Another example for this section is, “client smelled of alcohol, walked in an unsteady manner, and slurred his speech”. This is the section where you would document any interventions that were required and things like what parents brought to visits.

Assessment is the clinician’s evaluation of the family or client’s situation and differential diagnosis (for in home therapy). The differential diagnosis includes all possible causes of chief complaint brought by the client or person requesting help. It includes areas of strength and difficulties. It provides a sound systemic formulation of the problem in the context of the family and other contexts. This section is where you assess in descriptive terms, the client’s performance during the session and/or the session itself. For example, “Susan showed a significant improvement in her parenting skills over the last three sessions as she played with her daughter without prompting and responded to her needs for diaper changes. Overall this was a good session with no concerns to note”. You can document “What has been mastered? What will need additional practice? “. This is where you write your clinical impressions (how would you label the client’s behavior and the
reasons-if any-for this behavior). For Supervised Visits, this is where you would comment on the quality of the parent/child interaction during the visit and also comment on how the child responded to the parent’s parenting during the visit.

The Plan is the clinician’s plan of action, if any, and includes recommendations to the client or DCF worker, therapeutic interventions, and a prognosis (poor, guarded, fair, good or excellent). What do you intend to do? When will you see the client again? How often? Will anyone else speak with this client? Will you or the DCF social worker refer this client for other services? Will you consult with other professionals? What did the client/parent agree to do?

Think of the progress note as a legal, clinical document. The progress notes may be read by your client, clinical supervisor, a judge or an attorney, a DCF worker, etc. Each progress note should at least respond to the following questions: Who was present in the session? What did the participants speak about? What were the dynamics present in the session? What did the clinician/provider do in the session? What were the results of the interventions? What did the client(S) and the clinician/provider agree to do in the future?

Please use third person when referring to yourself. In example, instead of using I statements use “this writer” or “this provider” or “this therapist”.