SOAP Note Cheat Sheet

Reviewed by the BastionGPT Clinical Advisory Board · July 2026

A SOAP note is a progress note format that organizes a clinical encounter into four sections: Subjective, Objective, Assessment, and Plan. It gives providers, payers, and auditors a structure they can read quickly. A typical therapy SOAP note runs 150 to 350 words.

S – Subjective the client's report, in their frame

Do: capture presenting concerns, symptoms, stressors, and progress since last session. Anchor with one or two short client quotes.
Pitfall: filling this section with your interpretation; interpretation belongs in Assessment.

O – Objective what you observed and measured

Do: record appearance, affect, engagement, and mental status highlights. Include scores (PHQ-9, GAD-7) and attendance.
Pitfall: writing "client seemed anxious" as objective; describe the observable behavior instead.

A – Assessment your clinical judgment; where the note earns medical necessity

Do: tie progress to a numbered treatment plan goal. State response to interventions and current risk status.
Pitfall: repeating S and O instead of interpreting them.

P – Plan what happens next

Do: list interventions, homework, referrals, and the next appointment, with dates. Note any safety planning.
Pitfall: a bare "continue treatment"; tie the plan to a goal.

Before you sign

- [ ] Risk addressed in S and A, even when low
- [ ] At least one observable or score in O (PHQ-9, GAD-7, behavior)
- [ ] Assessment ties the session to a numbered treatment plan goal
- [ ] Plan items are specific and dated
- [ ] Start/stop or total time recorded for time-based codes (90832, 90834, 90837)
- [ ] Signed with credentials, dated promptly

Drafting with AI

Capture 30 seconds of bullets in session: topics discussed, interventions used, scores, risk status, plan changes.

"Draft a SOAP note from these bullets for a CBT session, GAD, session 6 of 12: …"

Never paste client-identifying information into consumer AI tools. BastionGPT is HIPAA-compliant with a signed BAA on every plan.

150–350 words	10–20 min by hand	After each session	Care team · payers · auditors
typical length	clinical team estimate	when it's written	who reads it

Full guide, sample note, and compliance notes:
bastiongpt.com/template/soap-note

SOAP Note Template

Copy, print, or adapt for your practice · all fields optional by your org's policy

Client (initials): Date: Session #:

Service: ☐ individual ☐ group ☐ telehealth Start / stop time:

S – Subjective

Client's report: concerns, symptoms, stressors, progress since last session, short quotes

O – Objective

Observed and measured: appearance, affect, engagement, mental status, scores (PHQ-9, GAD-7)

A – Assessment

Clinical judgment: progress toward treatment plan goal, response to interventions, risk status

P – Plan

Next steps: interventions, homework, referrals, next appointment, safety planning

Clinician signature / credentials: Date signed: