



Writing a SOAP Note

S

Subjective - Client's chief complaint or presenting problem; Includes direct client quotes

O

Objective - Client appearance, speech, mood, affect, behaviors, etc

A

Assessment - Diagnosis and differential diagnosis; Counselor impressions and client's progress

P

Plan - Focus, interventions, referrals planned for next session, follow up on homework

Nursing Progress Note Mnemonic Soap

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