

Psychiatric SOAP Note Template

There are different ways in which to complete a Psychiatric SOAP (Subjective, Objective, Assessment, and Plan) Note. This is a template that is meant to guide you as you continue to develop your style of SOAP in the psychiatric practice setting. Refer to the Psychiatric SOAP Note PowerPoint for further detail about each of these sections.

Criteria

Clinical Notes

Subjective

Include chief complaint, subjective information from the patient, names and relations of others present in the interview, and basic demographic information of the patient. HPI, Past Medical and Psychiatric History, Social History.

Objective

This is where the “facts” are located. Include relevant labs, test results, vitals, and Review of Systems (ROS) – if ROS is negative, “ROS noncontributory,” or “ROS negative with the exception of...” Include MSE, risk assessment here, and psychiatric screening measure results.

Assessment

Include your findings, diagnosis and differentials (DSM-5 and any other medical diagnosis) along with ICD-10 codes, treatment options, and patient input regarding treatment options (if possible), including obstacles to treatment.

Plan

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J Dewey



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The Psychiatric Soap Note Virginia Tech Introduction

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