# **Initial Psychiatric SOAP Note Template**

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# **Psychotherapy Treatment Plan 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.

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| **Criteria** | **Clinical Notes** |
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| **Informed Consent** | Informed consent given to patient about psychiatric interview process and psychiatric/psychotherapy treatment. Verbal and Written consent obtained. Patient has the ability/capacity to respond and appears to understand the risk, benefits, and(Will review additional consent during treatment plan discussion) |
| **Subjective** | Verify Patient Name: DOB:Minor:Accompanied by:Demographic:Gender Identifier Note:CC:HPI:Pertinent history in record and from patient: XDuring assessment: Patient describes their mood as X and indicated it has gotten worse in TIME.Patient self-esteem appears fair, no reported feelings of excessive guilt, no reported anhedonia, does not report sleep disturbance, does not report change in appetite, does not report libido disturbances, does not report change in energy,no reported changes in concentration or memory.Patient does not report increased activity, agitation, risk-taking behaviors, pressured speech, or euphoria. Patient does not report excessive fears, worries or panic attacks. Patient does not report hallucinations, delusions, obsessions or compulsions. Patient’s activity level, attention and concentration were observed to be within normal limits. Patient does not report symptoms of eating disorder. There is no recent weight loss or gain. Patient does not report symptoms of a characterological nature.SI/ HI/ AV: Patient currently denies suicidal ideation, denies SIBx, denies homicidal ideation, denies violent behavior, denies inappropriate/illegal behaviors.Allergies: NKDFA.(medication & food)Past Medical Hx: Medical history: Denies cardiac, respiratory, endocrine and neurological issues, including history head injury.Patient denies history of chronic infection, including MRSA, TB, HIV and Hep C.Surgical history no surgical history reportedPast Psychiatric Hx:**Previous psychiatric diagnoses**: none reported. Describes stable course of illness. **Previous medication trials**: none reported.**Safety concerns:** History of Violence to Self: none reported History of Violence to Others: none reported Auditory Hallucinations:Visual Hallucinations:**Mental health treatment history** discussed:History of outpatient treatment: not reported Previous psychiatric hospitalizations: not reported Prior substance abuse treatment: not reported **Trauma history:** Client does not report history of trauma including abuse, domestic violence, witnessing disturbing events.**Substance Use:** Client denies use or dependence on nicotine/tobacco products. Client does not report abuse of or dependence on ETOH, and other illicit drugs.Current Medications: No current medications. (Contraceptives): Supplements:Past Psych Med Trials:Family Medical Hx:Family Psychiatric Hx: Substance use Suicides Psychiatric diagnoses/hospitalization Developmental diagnosesSocial History:Occupational History: currently unemployed. Denies previous occupational hx Military service History: Denies previous military hx.Education history: completed HS and vocational certificate Developmental History: no significant details reported. (Childhood History)Legal History: no reported/known legal issues, no reported/known conservator or guardian. Spiritual/Cultural Considerations: none reported. ROS:Constitutional: No report of fever or weight loss. Eyes: No report of acute vision changes or eye pain. ENT: No report of hearing changes or difficulty swallowing. Cardiac: No report of chest pain, edema or orthopnea. Respiratory: Denies dyspnea, cough or wheeze. GI: No report of abdominal pain. GU: No report of dysuria or hematuria. Musculoskeletal: No report of joint pain or swelling. Skin: No report of rash, lesion, abrasions. Neurologic: No report of seizures, blackout, numbness or focal weakness. Endocrine: No report of polyuria or polydipsia. Hematologic: No report of blood clots or easy bleeding. Allergy: No report of hives or allergic reaction. Reproductive: No report of significant issues. (females: GYN hx; abortions, miscarriages, pregnancies, hysterectomy, PCOS, etc…) |
| *Verify Patient:* Name, Assigned **identification** number (e.g., medical record number), Date of birth, Phone number, Social security number, Address, Photo.*Include demographics, chief complaint, subjective information from the patient, names and relations of others present in the interview.* *HPI:* *, Past Medical and Psychiatric History,**Current Medications, Previous Psych Med trials,* *Allergies.* *Social History, Family History.**Review of Systems (ROS) – if ROS is negative, “ROS noncontributory,” or “ROS negative with the exception of…”* |
| **Objective**  | **Vital Signs:** StableTemp: BP: HR: R: O2: Pain: Ht: Wt: BMI: BMI Range: LABS:Lab findings WNLTox screen: NegativeAlcohol: NegativeHCG: N/A Physical Exam:MSE:Patient is cooperative and conversant, appears without acute distress, and fully oriented x 4. Patient is dressed appropriately for age and season. Psychomotor activity appears within normal.Presents with appropriate eye contact, euthymic affect - full, even, congruent with reported mood of “x”. Speech: spontaneous, normal rate, appropriate volume/tone with no problems expressing self. TC: no abnormal content elicited, denies suicidal ideation and denies homicidal ideation. Process appears linear, coherent, goal-directed.Cognition appears grossly intact with appropriate attention span & concentration and average fund of knowledge. Judgment appears fair . Insight appears fairThe patient is able to articulate needs, is motivated for compliance and adherence to medication regimen. Patient is willing and able to participate with treatment, disposition, and discharge planning. |
| *This is where the “facts” are located.* *Vitals,* ***\*\*Physical Exam (if performed, will not be performed every visit in every setting)****Include relevant labs, test results, and Include MSE, risk assessment here, and psychiatric screening measure results.* |
| **Assessment** | DSM5 Diagnosis: with ICD-10 codesDx: - Dx: - Dx: - Patient has the ability/capacity appears to respond to psychiatric medications/psychotherapy and appears to understand the need for medications/psychotherapy and is willing to maintain adherent. Reviewed potential risks & benefits, Black Box warnings, and alternatives including declining treatment. |
| *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.**Informed Consent Ability* |
| **Plan** | Inpatient:Psychiatric. Admits to X as per HPI. Estimated stay 3-5 days Patient is found to be stable and has control of behavior. Patient likely poses a minimal risk to self and a minimal risk to others at this time. Patient denies abnormal perceptions and does not appear to be responding to internal stimuli.1. **Safety Risk**: Admit to IPLOC for safety and stabilization of symptoms.
2. **DX**: No changes to current medication, as listed in chart, at this time
3. **Health & Wellness**: Discussed current tobacco use. NRT not indicated.
4. **Follow-up**: Patient deferred to designated care team as needed
5. **Psychotherapy Detailed Plan attached below**

[x]  > 50% time spent counseling/coordination of care.Time spent in Psychotherapy 18 minutesVisit lasted 55 minutesBilling Codes for visit: XXXXXX\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_NAME, TITLEDate: Click here to enter a date. Time: X  |
| *Include a specific plan, ~~including medications & dosing & titration considerations, lab work ordered,~~ referrals to psychiatric and medical providers, therapy recommendations, holistic options and complimentary therapies, and rationale for your decisions. Include when you will want to see the patient next. This comprehensive plan should relate directly to your Assessment and include patient education.*  |

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| **Psychotherapy Treatment Plan** |
| Informed Consent Reviewed: (yes/no) (Date/Time) |
| Diagnosis: |
| Goal #1 | Objectives:1.2.3Objective Established: 1/9/15Targeted Completion: 2/28/15Completed on: | Interventions:1.2.3. |
| Goal #2 | Objectives:1.2.3Objective Established: 1/9/15Targeted Completion: 2/28/15Completed on: | Interventions:1.2.3. |
| Goal #3 | Objectives:1.2.3Objective Established: 1/9/15Targeted Completion: 2/28/15Completed on: | Interventions:1.2.3. |
| Frequency: 60 minutes per week Duration: 4 monthsProvider Signature & Date:Client Signature & Date: |