# 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. All the components are necessary for the psychiatric interview and later documentation. Refer to Carlat’s text, The Psychiatric Interview (2023), for further detail about each of these sections.

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| **Criteria** | **Clinical Notes** |
| **Subjective**-Chief complaint (pt’s own words)-People present for appt-Patient demographic info-History of present illness-Psychiatric ROS-Medical ROS-Family history (medical and psychiatric)-Patient medical history-Pt psychiatric hx-Social history-Trauma history-Substance use history |  |
| **Objective**-Complete mental status examination (MSE)-Vital signs-Physical assessment (relevant only)-Lab results from case-Risk assessment -Psychiatric screening measure results (PHQ-9, MMSE, etc.) |  |
| **Asssessment**-Case formulation/biopsychosocial assessment (a summary of the genetic vulnerabilities, attachment styles, employment, relationships, triggers/modifiable factors, medical conditions, and adverse experiences that may impact the clinical picture.)-Three differential diagnoses with brief rationale backed up by -DSM-5-TR. -Primary diagnosis-Medical diagnoses-Obstacles to treatment  |  |
| **Plan**-Patient specific-Pharmacologic (starting dose, titration, if any)-Medication education-Non-pharmacologic-Lab orders-Referrals-Follow up--Brief rationale for all treatment plan recommendations required.  |  |