THE SOCIAL WORK PROGRESSIVE

SOAP Note: Annotated Example

A real-world walkthrough you can hand to a student or study from yourself.

The Scenario

Client is a 34-year-old woman seen for ongoing individual therapy for major depressive disorder. She arrives twenty minutes late to her scheduled 2:00 p.m. session, sits down, and begins to cry. Her PHQ-9 today is 14, up from 9 at her last session two weeks ago. She denies current suicidal ideation when asked directly. She identifies her mother's recent terminal diagnosis as the trigger.

The Note

S	Client arrived 20 minutes late and stated, "I almost did not come today. I have been lying awake thinking about my mom." Client reported her mother was diagnosed with stage IV pancreatic cancer last week. Client described difficulty sleeping, loss of appetite, and feeling "frozen" at work. Denied current SI when asked directly.	**WHY IT WORKS** Uses the client's direct quote. Captures reported symptoms and the stated trigger. Notes the direct SI question and her response. No interpretation or diagnostic language.
O	Client was tearful throughout session, affect constricted, mood depressed. Oriented x3. Speech slowed but coherent. No psychomotor agitation. PHQ-9 = 14 (moderate), up from 9 on 03/26. Attendance this month: 2 of 3 scheduled sessions. Client engaged and tracking.	**WHY IT WORKS** Pure observation and measurement. Screener score with comparison. Appearance, affect, behavior, orientation. A second clinician would record the same details.
A	Client is presenting with an acute grief response layered on top of baseline MDD, consistent with anticipatory grief related to her mother's terminal diagnosis. PHQ-9 increase of 5 points suggests worsening depressive symptoms. Protective factors: engaged in treatment, intact social support, no current SI. Risk factors: sleep disruption, appetite loss, recent major stressor. Overall risk: low to moderate, actively monitoring.	**WHY IT WORKS** Synthesizes S and O. Names the clinical picture. Weighs risk and protective factors. Articulates a risk level, not just a restatement of diagnosis.
P	1. Continue weekly individual therapy; next session 04/16 at 2:00 p.m.	**WHY IT WORKS**

	2. Updated safety plan reviewed in session; client verbalized understanding and agreed to contact 988 or ED for acute SI. 3. Referred to grief support group at St. Luke's, starting 04/22. 4. Coordinate with Dr. Patel (psychiatrist) re: possible medication review; release on file. 5. Homework: sleep log and one 10-minute walk per day.	Specific, numbered, dated, named. A covering clinician could pick this up tomorrow. Every item has an owner and a next step.

What Makes This Note Strong

- The client's voice is preserved in quotation marks, not paraphrased.
- Every data point in the Objective can be pointed to or counted.
- The Assessment shows clinical reasoning, not just a diagnosis label.
- The Plan names who does what and when.
- Risk is addressed directly, not buried or implied.
- Cultural and contextual factors (the mother's diagnosis, social support) are named.