THE SOCIAL WORK PROGRESSIVE · FREE TOOLKIT

SOAP Notes Free Resource Toolkit

Everything you need to teach, learn, and practice SOAP notes through an advanced social work lens.

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What's Inside

1. **SOAP Notes at a Glance Cheat Sheet**
   A one-page quick reference. What belongs in each section, what does not, and the power verbs that make your writing clinical.
2. **Fillable SOAP Note Template**
   A clean, branded blank template for students, interns, and clinicians. Print it or fill it digitally.
3. **Annotated Example Walkthrough**
   A full sample SOAP note with side-by-side explanations showing exactly why each line works.
4. **Instructor Discussion Prompts**
   Five classroom-ready discussion questions aligned to CSWE Competencies and NASW ethics, plus an optional grading rubric.

HOW TO USE

Students: print the cheat sheet, keep the template in your clinical folder, study the annotated example.
Instructors: embed the companion video in your LMS and assign one or more discussion prompts for credit.

SOAP Notes at a Glance

What belongs in each section, what does not, and the verbs that make it clinical.

S — Subjective

The client's story in their words.

BELONGS HERE
- Direct quotes from the client
- Reported symptoms and history
- Stated feelings and concerns
- Reason for visit in their words

KEEP OUT
- Your interpretation
- Diagnostic labels
- Loaded words (manipulative, etc.)

POWER VERBS
reported, stated, described, denied, endorsed, identified

O — Objective

What you observed and measured.

BELONGS HERE
- Appearance, affect, behavior
- Orientation, speech, thought
- Screener scores (PHQ-9, GAD-7)
- Attendance and collateral data

KEEP OUT
- Opinions or guesses
- Anything you cannot point to
- Client's internal experience

POWER VERBS
observed, presented, scored, demonstrated, appeared, measured

A — Assessment

Your clinical reasoning.

BELONGS HERE
- Synthesis of S and O
- Diagnosis and formulation
- Risk and protective factors
- Strengths and context

KEEP OUT
- Restating the diagnosis
- New data not in S or O
- One-line shrug (doing well)

POWER VERBS
consistent with, suggests, indicates, reflects, warrants, formulates

P — Plan

What happens next and by when.

BELONGS HERE
- Specific interventions
- Frequency and dates
- Named parties and referrals
- Safety plan and homework

KEEP OUT
- Vague monitoring language
- Plans with no owner or date
- Copy-paste from last session

POWER VERBS
will attend, will complete, will contact, referred to, coordinate with, schedule

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SOAP Note Template

A clean, fillable template for students, interns, and clinicians.

Client Initials	Session Date	Session #	Clinician

S — Subjective

Client's story in their words. Direct quotes welcome. Reported symptoms, history, feelings.

O — Objective

Observable and measurable data. Appearance, affect, behavior, screener scores, collateral.

A — Assessment

Your clinical reasoning. Synthesis of S and O. Diagnosis, risk, strengths, formulation.

P

Plan

What happens next. Specific, measurable, named parties, dates. Homework, referrals, safety.

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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. 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.	**WHY IT WORKS** 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.

FOR INSTRUCTORS

SOAP Notes Discussion Prompts

Five classroom-ready discussion questions to pair with the video.

These prompts are designed to pair with the SOAP Notes video from The Social Work Progressive. They can be used as in-class discussion, asynchronous discussion board posts, small-group breakout activities, or short written reflections. Each prompt connects to at least one CSWE Core Competency and is appropriate for BSW and foundational MSW courses.

How to Use

- Assign students to watch the SOAP Notes video before class or as part of a module.
- Choose one or more prompts below based on your learning objectives for the week.
- Encourage students to cite specific moments from the video in their responses.
- For online courses, post the prompts in your LMS discussion board with a 250 to 400 word response requirement and one peer reply.

PROMPT 1 Voice in the Subjective

The video emphasizes preserving the client's voice in the Subjective section and keeping interpretation out of it. Describe a moment, either from a field experience, a practicum simulation, or a role play, when it felt difficult to capture a client's story without inserting your own interpretation. What made it difficult? What language or technique could help you stay in the client's voice while still writing a clinically useful note? Connect your answer to CSWE Competency 6 on engagement.

PROMPT 2 Objective vs. Assessment

Consider this line: "The client is avoidant and not invested in treatment." Rewrite this line twice. First, rewrite it so it would fit in the Objective section using only observable, measurable data. Second, rewrite it so it would fit in the Assessment section as genuine clinical reasoning. Then explain in two to three sentences why the distinction matters for the client, the chart, and your future self reading the note.

PROMPT 3 Ethics in the Chart

The video references NASW Code of Ethics standards 1.03 on informed consent and 1.05 on cultural competence as they apply to documentation. Pick one standard and describe a specific documentation choice (word selection, what to include, what to leave out) that would put that standard into practice. Then describe a choice that would violate it. Use a hypothetical client scenario to make your examples concrete.

PROMPT 4 The Pitfall You Are Most Likely to Make

The video identifies six common SOAP note pitfalls. Which one do you think you are most likely to fall into and why? Be honest. What is a specific habit, structure, or self-check you could build into your documentation routine to catch yourself before that pitfall shows up in a real chart? Connect your answer to CSWE Competency 1 on ethical and professional behavior.

PROMPT 5 The Plan That Actually Works

Review the Plan section in the video's annotated example. Identify three specific qualities that make that Plan strong. Then draft a Plan for a client you have worked with (real or hypothetical, de-identified) that demonstrates those same qualities. Your plan should name at least one measurable intervention, one safety consideration, and one coordination step with another provider or system.

Suggested Grading Rubric (optional)

- Demonstrates clear understanding of the SOAP section being discussed (30%)
- Applies CSWE Competencies or NASW standards with specificity (25%)
- Uses a concrete example, not just abstract theory (25%)
- Writing is professional and free of documentation pitfalls (20%)