

Psychiatry SOAP note example

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A fictional psychiatry SOAP note example that separates patient report, observed mental status findings, risk formulation, clinical assessment, and follow-up.

Clinical boundary

This example is not a suicide-risk tool, diagnostic instrument, emergency protocol, medication guide, or substitute for a complete psychiatric assessment and immediate local escalation when safety is at risk.

Fictional SOAP example

Subjective

Fictional adult patient reports that mood has been more stable during the past month, with continued difficulty initiating sleep on several nights per week. The patient describes work stress and reports attending scheduled therapy visits.

The patient denies current thoughts of suicide or harm to others in this fictional scenario. This statement is one element of the encounter and does not replace a complete, context-specific risk assessment.

Objective

Observed during the fictional visit: appropriately dressed, cooperative, normal-volume speech, linear and goal-directed thought process, and affect congruent with the discussed content.

No perceptual disturbance is reported or observed during the encounter. Orientation, attention, insight, and judgment are documented only to the extent actually assessed.

Assessment

Previously documented depressive and anxiety symptoms are described as improved overall, with persistent sleep-onset difficulty and ongoing occupational stress. The note distinguishes patient report from observed mental status findings.

Acute risk is not determined by a single denial statement. The clinician's formulation should integrate history, current symptoms, observed findings, protective factors, access to means, collateral information when appropriate, and local standards.

Plan

Document the clinician's patient-specific treatment decisions, consent discussion, monitoring, safety planning when indicated, follow-up interval, and escalation instructions.

Record any collateral source, psychotherapy service, medication review, or referral only if it occurred and belongs in the encounter record.

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Encounter context, confidentiality, and information sources

Interval symptoms and functioning

Medication, adherence, benefit, and adverse effects

Substance use and medical context

Patient-reported safety information

Observed mental status examination

Risk formulation and protective factors

Assessment, monitoring, follow-up, and contingencies

Review checklist

- Reported versus observed mental-state findings
- Confidentiality and collateral-information context
- Risk rationale, protective factors, and actions taken
- Monitoring, follow-up, and escalation contingencies

Sources consulted

NCBI Bookshelf, SOAP Notes: <https://www.ncbi.nlm.nih.gov/books/NBK482263/>

AAFP, Writing Clinical Notes: Have We Made Progress?: <https://www.aafp.org/fpm/2022/0700/writing-clinical-notes>

APA, Practice Guideline for the Psychiatric Evaluation of Adults: <https://www.psychiatry.org/File%20Library/Psychiatrists/Practice/Clinical%20Practice%20Guidelines/psychevaladults.pdf>

AAFP, Mental Status Examination in Primary Care:
<https://www.aafp.org/afp/2024/0100/mental-status-examination.pdf>