**SOAP NOTES FOR PSYCHIATRIST**

**Subjective**

Ms. M. states that she is "doing okay." Ms. M. states that her depressive symptomatology has improved slightly; she still feels perpetually "sad." Ms. M. states her sleep patterns are still troubled, but her "sleep quality is improving" and getting "4 hours sleep per night" She expresses concern with my note-taking, causing her to be anxious during the session. She also is worried about experiencing occasional shortness of breath. She also states that "healthcare providers make her anxious and want to know where her medical records are being kept."

**Objective**

Ms. M. is alert. Her mood is unstable but improved slightly, and she is improving her ability to regulate her emotions.

**Assessment**

Ms. M. has a major depressive disorder.

**Plan**

Ms. M. will continue taking 20 milligrams of sertraline per day. If her symptoms do not improve in two weeks, the clinician will consider titrating the dose up to 40 mg. Ms. M. will continue outpatient counseling and patient education and handout. Comprehensive assessment and plan to be completed by Ms. M's case manager. The SOAP note could include data such as Ms. M vital signs, patient's chart, HPI, and lab work under the Objective section to monitor his medication's effects.