**SOAP NOTE**

**Subjective**

 Referring to what your client tells you

**Objective**

What you the clinician observed especially regarding the subjective

**Assessment**

Your clinical assessment, bridging the objective and subjective

**Plan**

Your clinical plan, recommendations, interventions etc.

* Client name, date and time of appointment
* CPT code for the service rendered
* Mental status etc.
* Danger to self
* Interventions
* Response to intervention
* Client concerns
* Fees collected
* Next appointment
* and more…