THE PSYCHIATRIC
SOAP NOTE

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The SOAP note in Psychiatry

Many students ask about how to write a SOAP note on a patient presenting with psychiatric complaints. Perhaps this is because they perceive the illnesses as different or the language describing the findings as different. The truth is that although each specialty of medicine has its own language and terminology, good documentation follows a very typical structure which reflects the foundations of deductive reasoning and recording the patient's progress with treatment. If we consider the purpose of documentation in any medical case it should guide us as to the mechanics of how it is done.

In Psychiatry, we often document a patient's current condition and progress in treatment with SOAP notes. As you know, SOAP stands for the areas of documentation that are considered vital components in order to achieve our goals with treatment. In Psychiatry, some of the specifics may be unique; however, the structure of the information and its recording are not. In the subjective portion of the note, one should find historical information that is obtained from the patient, and/or corroborating sources such as their family or caregiver. In the objective portion of the note, the reader should encounter information reflecting the functioning of the body including the focused area of neurological
functioning called the **Mental Status Exam**. Remember that the Mental Status Exam can never be taken out of the context of the overall medical condition of the patient and only describes the raw data concerning functioning, not the potential causes of dysfunction. The findings are then summarized in the **assessment** portion of the note and some form of differential diagnosis is constructed. In the final portion of the note, the **Plan** section, a roadmap is laid out in which the clinician should construct the plan to address the specific deficits previously described in the assessment. In other words, the plan should always be related to the assessment and on the following visit, progress with the plan can be appropriately assessed. One might think of this as a continuum of patient care with intermittent documentation of where that patient lies along the continuum at that point in time and what to do to get the patient back on a treatment path if he/she is not.

As you develop your skills in medical assessment you will appreciate more and more how little difference there is in the overall structure of our assessments even though we may be looking for very specific things related to our specialty of medicine. Below you will find a sample SOAP note in outline form very much like you would see on a real patient who would be presenting for follow up of depression.
THE NOTE

SUBJECTIVE:
Since last visit patient states he is feeling better although still somewhat depressed, is compliant with Venlafaxine as Rxed and denies side effects (progress since last visit with current issues). He continues to report early morning awakening. Appetite is improved and weight is stable. Patient still reports some difficulty with concentrating on his work and feeling “exhausted” by the end of the day. ROS is otherwise negative (Review of systems for both non-specific and specific symptoms which may be related to depression). Patient denies currently using substances (historical information which may be relevant to symptoms and differential diagnosis).

Medications: HCTZ 25mg. qdaily, simvastatin 10mg qdaily, Venlafaxine XR 75mg. qam.

Allergies: none

OBJECTIVE:
BP 130/74 P80 wt. 167 (indication of overall health status and specific issue of potential weight loss)

Heart with regular rate and rhythm, no murmurs

Lungs clear to auscultation

Neurological status of strength, sensation, cranial nerves and reflexes is unremarkable. Mental status reveals appropriately dressed, neatly groomed male. Behavior is appropriate and speech is articulate. Mood is “a little bit down”. Affect is slightly constricted but stable and congruent. Thought process is logical and goal directed and Thought content shows no evidence of delusional thinking. The patient denies suicidal or homicidal ideation or intent. No perceptual disturbances are apparent. Memory is intact for recent and remote events and the patient is able to recall 2/3 items after 5 minutes. He is able to complete serial subtractions by 7 from 100 x 2. His insight appears to be fair and judgment is appropriate by testing. (Notice that the Mental Status Exam is
included in the neurological status of the patient and although expanded is documented as part of the physical exam)

ASSESSMENT:

Axis I: Major Depressive Disorder, single episode, improving with venlafaxine XR.

Axis II: none

Axis III: hypertension and hyperlipidemia, controlled

Axis IV: none

Axis V: GAF approximately 72/100

(The assessment should address not only the problem/diagnosis but also any changes and where the patient is along the treatment continuum. You will notice the multi-axial diagnostic structure commonly used in psychiatry.)

PLAN:

1. Will increase dose of venlafaxine XR to 150mg. qam with continued monitoring of BP. Discussed risk vs. benefits and potential side effects of this medication and the patient is in continued agreement with the medication. *(Note that informed consent is addressed)*

2. Educated the patient on general health and safety measures and encouraged him to come to the ED if he were to experience suicidal/homicidal thoughts or significant worsening of symptoms. He is aware and agreeable. *(What things might be included in general health education?)*

3. The patient will follow up in 1 month for reassessment of progress with target symptoms of depression as discussed with the patient. He is aware to call if significant questions or concerns before then.

*(The plan should set out a clear road map for the patient and/or another clinician to be able to continue the treatment if needed. Suppose you were seeing this patient for follow up appointment for your sick colleague? Would you be able to easily know what the plan is and how to follow it?)*