The Private Practice Progress Note Pack

Print-ready SOAP, DAP and BIRP templates — blank and guided — plus a ten-question self-audit for notes you have already written.

What's inside

- Blank templates for SOAP, DAP and BIRP, with ruled writing space
- Guided versions of each, with the questions to answer in every section
- The three-sentence Assessment — a formula for the section that takes longest
- The ten-question self-audit — run it on your last five notes

How to use it

Print the blank templates you need and keep a stack in your desk, or use the guided versions until the structure is automatic. Nothing here needs to be filled in on a screen.

SOAP — blank

Subjective, Objective, Assessment, Plan.

S **Subjective** what the client reports

O **Objective** what you observed and measured

A **Assessment** your clinical reasoning

P **Plan** what happens next

Clinician _____ Client ID _____ Date _____ Session # _____

DAP — blank

Data, Assessment, Plan. Faster, with report and observation merged.

D Data

reported and observed together

A Assessment

your clinical reasoning

P Plan

what happens next

Clinician _____ Client ID _____ Date _____ Session # _____

BIRP — blank

Behavior, Intervention, Response, Plan. Foregrounds what you did.

B Behavior

presentation and report

I Intervention

what you delivered

R Response

how the client responded

P Plan

what happens next

Clinician _____ Client ID _____ Date _____ Session # _____

SOAP — guided

Use this until the structure is automatic. Answer the prompts rather than filling the boxes.

S — Subjective

- ☐ What did the client say about how the week went?
- ☐ Symptoms: frequency, duration, intensity?
- ☐ Any significant events since last session?
- ☐ Did they do the between-session work? What got in the way?
- ☐ One quote worth recording verbatim?

O — Objective

- ☐ Appearance, grooming, punctuality?
- ☐ Speech, affect, mood presentation, orientation?
- ☐ Any measure administered, and the score?
- ☐ Risk indicators observed — or denied on direct questioning?
- ☐ Which interventions did you actually deliver? Name the techniques.

A — Assessment

- ☐ What changed since last session, and what evidence shows it?
- ☐ What do you think explains that change?
- ☐ What does it mean for the treatment plan?
- ☐ Progress against which specific goal?
- ☐ Risk judgment and the reasoning behind it?

P — Plan

- ☐ Session frequency and length?
- ☐ Homework — specific enough that the client knows what to do?
- ☐ Focus for next session?
- ☐ When will you re-administer measures?
- ☐ Referrals, consultations, coordination of care?

The three-sentence Assessment

The Assessment is the section auditors read first and the one most often left thin. Three sentences is a floor, not a ceiling — but a note that has all three is defensible regardless of length.

1. What changed, and what shows it.
   "Avoidance has narrowed from all social settings to work meetings; GAD-7 down from 16 to 11."
2. What you think explains it.
   "Consistent with the exposure hierarchy work in sessions 4–6 rather than situational relief, given the change held across a high-stress week."
3. What that means for treatment.
   "Ready to move to hierarchy step 4; sleep remains the lagging domain and needs a different intervention."

The ten-question self-audit

Run this on your last five notes, not your next five. Reviewing finished work tells you what your habits actually are.

- ☐ Does every line in Objective describe something you could see, hear or measure?
- ☐ Does the Assessment say what changed, not just what happened?
- ☐ Is there evidence in S or O supporting every claim in A?
- ☐ Could a covering clinician run next week's session from the Plan alone?
- ☐ Is homework specific enough that the client would know what to do?
- ☐ Is risk addressed — including when the answer was negative?
- ☐ Is every inference labelled as inference rather than stated as fact?
- ☐ Would this note look different from the previous session's?
- ☐ Is anyone other than your client identifiable in it?
- ☐ Was it written within 24 hours of the session?

Written by digitalinz.com. The full guides — including three complete worked notes, the nine mistakes that show up in documentation review, and a step-by-step writing workflow — are free at digitalinz.com/soap-notes-for-therapists