



# 1. DAP NOTE TEMPLATE

## DAP Note Template

Client Initials: \_\_\_\_\_ Date: \_\_\_\_\_ Session #: \_\_\_\_\_

### Data (Subjective):

Client reported feeling \_\_\_\_\_ due to \_\_\_\_\_.

**Main concerns discussed:** \_\_\_\_\_.

**Mood:** \_\_\_\_\_

(e.g., anxious, sad, irritable).

**Affect:** \_\_\_\_\_

(e.g., congruent, flat, labile).

**Any risk concerns:** \_\_\_\_\_

(e.g., no SI/HI, passive thoughts, safe).

## 2 SOAP NOTE TEMPLATE

**Client Initials:** \_\_\_\_\_ **Date:** \_\_\_\_\_ **Session #:** \_\_\_\_\_

### **Subjective:**

Client reports: "\_\_\_\_\_".

Main issues discussed: \_\_\_\_\_.

Current stressors: \_\_\_\_\_.

Sleep/Appetite/Energy: \_\_\_\_\_.

Any symptoms of anxiety, depression, or trauma: \_\_\_\_\_.

### **Objective:**

Observed behavior: \_\_\_\_\_

(e.g., made eye contact, fidgeting, tearful).

Speech: \_\_\_\_\_

(e.g., normal, slow, rapid).

Mood: \_\_\_\_\_

(as stated by client).

Affect: \_\_\_\_\_

(as observed by therapist).

# SOAP NOTE TEMPLATE

## Assessment:

### Progress toward goals:

Goal 1: “\_\_\_\_\_”

Status: \_\_\_\_\_

Goal 2: “\_\_\_\_\_”

Status: \_\_\_\_\_

Clinical impression: \_\_\_\_\_

(e.g., moderate anxiety, improving coping skills).

Risk assessment: \_\_\_\_\_

(e.g., denies SI/HI, safety plan in place).

## Plan:

Therapeutic approach: \_\_\_\_\_

(e.g., CBT, supportive counseling).

Interventions used: \_\_\_\_\_.

Homework assigned: \_\_\_\_\_.

Next session: \_\_\_\_\_.

# QUICK NOTE TEMPLATE

**Client Initials:** \_\_\_\_\_ **Date:** \_\_\_\_\_ **Session #:** \_\_\_\_\_

## **Today's Focus:**

(e.g., panic attacks, relationship conflict, grounding techniques)

## **Progress:**

(e.g., identified triggers, practiced breathing, insight into pattern)

## **Intervention Used:**

(e.g., CBT, reflection, psychoeducation, EMDR prep)

## **Homework Assigned:**

(e.g., thought record, mindfulness practice, journaling)