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SOAP Note Writing Checklist

Use this comprehensive checklist to ensure each SOAP note you write is accurate, complete, and professionally documented. This tool supports social workers, clinicians, therapists, case managers, and all healthcare practitioners in delivering high-quality documentation.

- ☐ Subjective – Did I capture what the client or patient said in their own words?
- ☐ Objective – Did I document observable facts like behavior or test results?
- ☐ Assessment – Have I clearly explained my interpretation or diagnosis?
- ☐ Plan – Did I outline next steps, timelines, or referrals?
- ☐ Tone – Is it professional, respectful, and neutral?
- ☐ Spelling & Grammar – Did I proofread before saving or sending?
- ☐ Format – Does it follow the proper SOAP note structure?
- ☐ Storage – Is the note saved securely in the right location?
- ☐ Clarity – Is each section clear and easy for others to understand?
- ☐ Relevance – Did I avoid unnecessary details and stay focused on the session's goals?
- ☐ Consistency – Are abbreviations and terminology used consistently throughout the note?
- ☐ Risk Factors – Did I document any red flags or potential risks clearly?
- ☐ Follow-Up – Did I include a plan for checking in or evaluating outcomes?
- ☐ Billing – Does this note support billing or insurance documentation (if applicable)?
- ☐ Confidentiality – Have I ensured all information respects client privacy?
- ☐ Timeliness – Was this note completed as close to the session time as possible?

- ☐ Professional Voice – Have I avoided slang, casual language, or personal opinions?
- ☐ Legal Readiness – Would this note be defensible in a legal or audit setting?
- ☐ Outcome Focus – Does the note show how the session moved the client toward a goal?

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<https://www.socialworkportal.com/>
