

Treatment plan essay examples

[Profession](#), [Writer](#)



I need this paper sent back for revision. The writer missed the diagnosis. All I need for the writer to do is to create a SOAP note that would follow the clients visit. I need this done as soon as possible.

S. O. A. P. stands for Subjective, Objective, Assessment, and Plan. Some people prefer D. A. P. notes -- D. A. P. stands for Description, Analysis, and Plan.

S. O. A. P Notes

Subjective: Subjective experience of the client as related/reported by the client. Often direct quotes from the client of his/her problems or complaints. Examples include, " I had an awful week," " I'm feeling really depressed," " I hate my mother," " I can't seem to stop worrying about my grade," " I haven't slept in two days," etc. Also can be statements made by client that you summarize without using quotes.

Objective: An objective account of the client appearance and behaviors. May include client dress/clothing, posturing, eye contact, timeliness to session, affect, activity, speech, etc. All the information in this section should be objective in the sense that it could be verified by observers and contains no analysis/judgment on your part. The Objective section should provide a behavioral picture of the client.

Plan: What you plan to do in the next session. Includes homework assignments, planned exercises or techniques, etc. When writing this section, ask yourself, " Following this theory, what is it I want to remember to do with this client?" or " What do I want to cover with them next week?" A plan should always be theory-specific.

I need this case number revised. All I need for the writer to do is to create a SOAP note for the client .