

Therapy progress notes template pack

SOAP, DAP and couples session layouts, each with prompts and a short risk section.

What this is

Three ready-to-edit progress note layouts for the sessions you run most: SOAP for individual sessions, DAP when you want a faster note, and a couples session note. Every layout has writing prompts, a short risk section and a sign-and-lock block, with a space for dated addenda so you never have to change an entry that has been signed.

How to use it

- Choose the layout that suits the session and copy it for each client. The guide page helps you decide.
- Fill in the note at the time of the session or soon afterwards, then sign and date it.
- Never delete or overwrite a signed entry. Corrections and late additions go in the addendum block.
- Delete the read-me, guide and last pages if you do not want them in your files.

Before you use it

Use the wording your scope allows. The assessment sections say "clinical impression". Use the language that fits your registration category and scope of practice.

A risk checklist is not a risk assessment. The risk section prompts you to record what you asked, what you found, your reasoning and what you did. Suicide risk should always be assessed in a clinical interview.

Check the retention rules. The Council's record-keeping guideline (Booklet 9, 2016) says adult records are kept for at least 6 years after they become dormant and children's records until the 21st birthday. A review draft from 2022 exists, so re-check the current version.

What we checked

- Health Professions Council of South Africa, Keeping of Patient Records, Booklet 9 (September 2016): what a record must contain, entries made at or after the consultation, signed, corrections by a single line with date, signature and reason, late entries dated and signed, secure electronic storage. [Booklet 9](#)
- Purdue Online Writing Lab, SOAP notes: Subjective, Objective, Assessment, Plan, written clearly enough for another provider to continue the care. [Purdue OWL](#)
- Shah and colleagues (2025), TN-Eval: complete, concise and faithful therapy notes. Therapist-written notes most often left out symptoms and mental state observations. [arXiv](#)
- American Counseling Association, practice brief on suicide risk assessment: gather past, recent and present information, weigh risk and protective factors, and assess within a clinical interview. [Practice brief](#)

Last checked: 2 October 2026. General information only, not legal or professional advice. Not approved or endorsed by the Health Professions Council of South Africa.

Choosing a format and writing a good note

Layout	Best for	How it is built
SOAP	Individual sessions where you want a clear separation of what the client said and what you saw.	Subjective, Objective, Assessment, Plan.
DAP	A faster note. Merges the client's account and your observations into one section.	Data, Assessment, Plan.
Couples session note	Joint sessions with two partners. Records each partner's view, the patterns you saw and the safety check for both.	Present, Themes, Interaction, Interventions, Progress, Safety, Plan.

No format has been shown to be better than the others. Choose the one you will complete consistently.

Six habits of a good note

- **Be complete.** Cover who, when and where, what the client reported, what you observed, what you did, and the plan. In a 2025 study of therapy notes, therapists most often left out symptoms and observations of the client's mental state.
- **Be concise.** Every sentence should earn its place. Write what happened, not everything you thought.
- **Stay faithful to the session.** Keep what the client said and what you observed separate from your interpretation, and label your interpretation as such.
- **Record the risk conversation.** If risk came up, note what you asked, what the client said, your reasoning and what you did.
- **Write at the time, or soon after.** The Council's guideline asks for entries made at or after the consultation. Sign and date every entry.
- **Never remove an entry.** Draw a single line through an error so it stays legible, then date, sign and give the reason. Add anything new as a dated addendum.

A short example (fictional)

Entry	
S	Reports arguments with partner on three nights this week. Sleeping about five hours. "I feel on edge all day." Wants to stay calm in conflict.
O	Tearful at the start, settled by mid-session. Speech slow, cooperative. Practised paced breathing. Brought thought record.
A	Anxiety about conflict continues. Partial progress: used breathing twice. No risk concerns raised.
P	Weekly sessions. Thought record three times. Next session: rehearse a difficult conversation. Review sleep.

Progress note: SOAP

Individual session · Subjective, Objective, Assessment, Plan

Client name

Client reference

Date

Start time

Session number

Place: ☐ Rooms ☐ Online ☐ Other

Attended: ☐ Yes ☐ Late ☐ Cancelled ☐ Did not attend

S Subjective

What the client reports: concerns, symptoms, events since the last session, progress on goals, in their own words where useful.

O Objective

What you observed: appearance, mood and affect, speech, behaviour, engagement. What you did in the session: techniques, exercises, homework reviewed.

A Assessment

Your clinical impression: how the client is doing, progress towards the goals, what is helping or getting in the way. Mark interpretation as interpretation.

P Plan

Next steps: focus of the next session, homework, frequency, referrals, anything to follow up.

Risk (complete every session; expand if any answer is yes)

Question	Answer
Thoughts of harming self	☐ None ☐ Passive (wishes not to be alive) ☐ Active
Plan, intent or access to means	☐ None ☐ Plan ☐ Intent ☐ Access to means
Thoughts of harming others	☐ None ☐ Present: [describe]
Safety at home and in relationships	☐ No concerns ☐ Concerns: [describe]
Protective factors	[supports, reasons for living, coping, future plans]
Risk level (your judgement)	☐ Low ☐ Moderate ☐ High
What you did	[safety plan, contact, consultation, referral, follow-up]

If any answer is yes, record what you asked, what the client said, your reasoning and your actions.

Sign and lock

Initials and surname (block letters)	Registration number
Signature	Date signed

Addendum or correction

Never delete or overwrite a signed entry. Draw a single line through an error so it stays legible, then date, sign and give the reason. Add new information here, dated and signed.

Date	Reason
Addendum text	
Signature	

Progress note: DAP

Individual session · Data, Assessment, Plan

Client name

Client reference

Date

Start time

Session number

Place: ☐ Rooms ☐ Online ☐ Other

Attended: ☐ Yes ☐ Late ☐ Cancelled ☐ Did not attend

D Data

What the client reported and what you observed, in one place: concerns, events, mood and affect, behaviour. What you did in the session.

A Assessment

Your clinical impression: progress towards goals, themes, strengths, what is getting in the way. Mark interpretation as interpretation.

P Plan

Next steps: focus of the next session, homework, frequency, referrals, anything to follow up.

Risk (complete every session; expand if any answer is yes)

Question	Answer
Thoughts of harming self	☐ None ☐ Passive (wishes not to be alive) ☐ Active
Plan, intent or access to means	☐ None ☐ Plan ☐ Intent ☐ Access to means
Thoughts of harming others	☐ None ☐ Present: [describe]
Safety at home and in relationships	☐ No concerns ☐ Concerns: [describe]
Protective factors	[supports, reasons for living, coping, future plans]
Risk level (your judgement)	☐ Low ☐ Moderate ☐ High
What you did	[safety plan, contact, consultation, referral, follow-up]

If any answer is yes, record what you asked, what the client said, your reasoning and your actions.

Sign and lock

Initials and surname (block letters)	Registration number
Signature	Date signed

Addendum or correction

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Addendum text	
Signature	

Progress note: couples session

Joint session · Present, Themes, Interaction, Interventions, Progress, Safety, Plan

Partner 1 name

Partner 2 name

Date

Start time

Session number

Place: ☐ Rooms ☐ Online ☐ Other

Present: ☐ Both partners ☐ Partner 1 only ☐ Partner 2 only

1 What each partner brought

Partner 1: the main concern or event this session, in brief. Partner 2: the main concern or event this session, in brief. Keep both views balanced.

2 Patterns and interaction

What you observed between them: how they communicate, where it escalates or shuts down, any repair attempts, strengths in the relationship.

3 What you did

Interventions and exercises used, skills taught, homework reviewed or set.

4 Progress and clinical impression

Progress towards the couple's agreed goals. What is helping, and what is in the way. Mark interpretation as interpretation.

5 Plan

Focus of the next session, homework for each partner, individual sessions if needed, referrals, anything to follow up.

Risk (complete every session; expand if any answer is yes)

Question	Answer
Thoughts of harming self	☐ None ☐ Passive (wishes not to be alive) ☐ Active
Plan, intent or access to means	☐ None ☐ Plan ☐ Intent ☐ Access to means
Thoughts of harming others	☐ None ☐ Present: [describe]
Relationship safety (each partner)	☐ No concerns ☐ Concerns: [describe]
Protective factors	[supports, reasons for living, coping, future plans]
Risk level (your judgement)	☐ Low ☐ Moderate ☐ High
What you did	[safety plan, contact, consultation, referral, follow-up]

If any answer is yes, record what you asked, what the client said, your reasoning and your actions.

Sign and lock

Initials and surname (block letters)	Registration number
Signature	Date signed

Addendum or correction

Never delete or overwrite a signed entry. Draw a single line through an error so it stays legible, then date, sign and give the reason. Add new information here, dated and signed.

Date	Reason
Addendum text	
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HPCSA-COMPLIANT NOTES

Tired of doing this manually?

Try *Wholistic Private Practice*

Copying templates, remembering the record-keeping rules and keeping corrections tidy is a lot to hold alone. In **Wholistic Private Practice**, session notes are structured for you and the system holds the standard, so you can hold the session.

- **Structured notes with a built-in risk assessment**, so the risk conversation is always recorded.
- **Sign and lock**. A signed entry cannot be edited. Corrections are added as dated addenda, as the guidelines ask.
- **A clear view of risk across your caseload**, so no at-risk client slips through the cracks.

See HPCSA-compliant notes →

Or visit wholisticprivatepractice.com

Free for up to 5 active clients. Join the waiting list to lock in the R39 per month founding rate. No per-claim fees and no percentage of your income.

Built by Sumarie Engelbrecht, a Registered Counsellor in active practice in Mbombela, for South African psychologists and Registered Counsellors.