

Intake Note Cheat Sheet

Beyond the Mirror Counseling & Wellness

An intake note captures the starting point of therapy. It documents why the client is seeking services, how they are functioning at the beginning of care, and the clinical information needed to support ethical treatment, continuity, and diagnostic understanding.

Intake notes are more comprehensive than progress notes and set the foundation for treatment planning.

Core Components of an Intake Note

1. Presenting Problem

Why the client is seeking therapy now

This section describes the client's primary concerns in their own words and in clinical language.

Include:

- What brought the client to therapy
- Current symptoms or stressors
- Duration and impact on daily functioning

Examples:

- Client presents with increased anxiety related to work stress and difficulty sleeping.
- Client reports ongoing struggles with body image and emotional regulation.

- Client stated, “I feel overwhelmed and don’t know how to manage everything.”
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2. Subjective Information

What the client reports

This reflects the client’s internal experience, history, and perspective.

Include:

- Client-reported mood and symptoms
- History of the presenting concern
- Relevant personal or relational stressors

Examples:

- Client reports chronic worry and difficulty relaxing.
 - Client shared feeling disconnected from others since a recent life transition.
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3. Objective Information

What the clinician observes

This section includes observable, measurable information noted during the intake session.

Include:

- Affect, mood, and behavior

- Engagement and presentation
- Orientation and speech

Examples:

- Client appeared tearful at times during the session.
- Affect congruent with reported mood.
- Client was alert, oriented, and engaged.

4. Mental Status Exam (MSE)

Clinical presentation at intake

The MSE is based on clinician observation, not interpretation.

Typically includes:

- Appearance and behavior
- Mood and affect
- Speech and thought process
- Orientation (person, place, time)
- Insight and judgment
- Attention and concentration

Example language:

- Client appeared well-groomed and oriented to person, place, and time.
 - Thought process was logical and goal-directed.
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5. Risk Assessment

Safety and level of risk

This section documents assessment of safety concerns and protective factors.

Include:

- Suicidal ideation (current or historical)
- Self-harm behaviors
- Homicidal ideation (if applicable)
- Protective factors
- Current level of risk

Examples:

- Client denies current suicidal ideation, intent, or plan.
 - Client reports historical passive suicidal thoughts with no current intent.
 - Protective factors include family support and motivation for treatment.
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6. Biopsychosocial Assessment

Whole-person context

This section integrates biological, psychological, and social factors. While the client completes much of this in paperwork, clinicians are responsible for clarifying responses and asking follow-up questions.

Include:

- Biological: sleep, health conditions, medications
 - Psychological: mood, trauma history, coping strategies
 - Social: relationships, work, housing, support systems
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7. SNAP Framework (if used)

Strengths, Needs, Abilities, Preferences

SNAP helps ensure the intake remains collaborative and client-centered.

Examples:

- Strengths include insight and motivation for treatment.
 - Needs include emotional regulation support.
 - Client prefers a collaborative, strengths-based approach.
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8. Diagnostic Impression & Justification

Initial clinical understanding

This section explains the clinician's diagnostic impression based on intake information.

Include:

- Provisional or formal diagnosis
- Symptom alignment with diagnostic criteria
- Functional impact

Use client quotes when possible

Examples:

- Client reports persistent anxiety, stating, “I feel on edge most of the time.”
- Client describes disrupted sleep and difficulty concentrating.

Including 2–3 client quotes strengthens diagnostic justification.

9. Initial Plan / Recommendations

Next steps following intake

This section outlines immediate clinical direction.

Include:

- Recommended frequency of sessions
- Initial focus areas
- Referrals or coordination if needed
- Safety planning (if applicable)

Examples:

- Recommend weekly individual therapy.
 - Focus initial sessions on emotional regulation and anxiety management.
 - Safety plan created and reviewed as appropriate.
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Helpful Reminders

- Intake notes establish the foundation for treatment
- Use the client's voice whenever possible
- Be thorough but relevant—avoid unnecessary detail
- When unsure, consult with supervision or seek consultation