Intake Note Cheat Sheet

Reviewed by the BastionGPT Clinical Advisory Board · July 2026

An intake note documents a new client's first clinical session: presenting problem, relevant history, a risk screen, mental status observations, an initial clinical impression, and the starting plan. The rest of the chart builds on it, so the details captured here get read for the whole episode of care.

Identifying information & referral one header block, findable in seconds
Do: put client identifiers, date, clinician, referral source, service type, and start/stop times together at the top.
Pitfall: scattering these details through the narrative; reviewers and records staff hunt for them later.

Presenting problem why now, in the client's frame
Do: capture the client's own words plus onset, duration, severity, and what prompted the contact.
Pitfall: recording only your clinical rephrasing; a short quote anchors medical necessity.

Relevant history psychiatric, medical, medications, family
Do: cover prior treatment, hospitalizations, medical conditions, current medications, and family psychiatric history.
Pitfall: writing "noncontributory" without asking; to an auditor it reads as not assessed.

Social context the life around the symptoms
Do: record living situation, relationships, work or school, legal involvement, and cultural factors the client raises.
Pitfall: overcollecting sensitive detail with no clinical use; everything here is part of the accessible record.

Substance use screen every intake
Do: ask about current and past use, substances, frequency, and most recent use, and record the answers.
Pitfall: skipping the screen because the presenting problem seems unrelated; intake is where screening is expected.

Risk screen ask, and record the answer either way
Do: document current and historical suicidal ideation, self-harm, and harm to others, protective factors, and any action taken.
Pitfall: leaving risk blank when findings are negative; the record should show you asked.

Mental status & measures observations plus baseline scores
Do: note appearance, speech, mood, affect, thought process, insight, and score baseline measures such as the PHQ-9 or GAD-7.
Pitfall: template MSE strings that contradict the narrative, such as "euthymic mood" above a tearful presentation.

Initial impression & plan the note's destination
Do: give a provisional diagnosis with rule-outs, initial goals, modality and frequency, referrals, and the next appointment.
Pitfall: an impression that floats free; every diagnosis needs supporting symptoms documented above it.

Before you sign

- [ ] Risk screen written out, even when negative
- [ ] Baseline measures scored and recorded
- [ ] Presenting problem carries the client's words
- [ ] Provisional diagnosis traces to documented symptoms
- [ ] Plan has modality, frequency, and a dated next step
- [ ] Consent documented; history asked, not assumed
- [ ] Signed with credentials, dated promptly

Drafting with AI

Capture 30 seconds of bullets after the first session: presenting problem quote, history highlights, substance and risk findings, scores, impression, plan.

"Draft a therapy intake note from these bullets, adult self-referral, anxiety after a job change, GAD-7 12, risk screen negative: …"

Never paste client-identifying information into consumer AI tools. BastionGPT is HIPAA-compliant with a signed BAA on every plan.

300–900 words	20–40 min by hand	First session	Care team · payers · auditors
typical length	clinical team estimate	each new episode of care	who reads it

Intake Note Template

Copy or print for your practice · Adapt fields to your organization's, payer's and jurisdiction's documentation requirements.

Client (initials): | DOB / age: | Date: | Start/stop times:

Clinician / credentials: | Referral source: | Service: intake / initial assessment

Presenting problem
In the client's words, plus onset, duration, severity, precipitant

Psychiatric, medical & medication history
Prior treatment, hospitalizations, medical conditions, current medications, family psychiatric history

Social context
Living situation, relationships, work or school, legal, cultural factors

Substance use
Substances, frequency, most recent use, history of problem use

Risk screen
SI, self-harm, harm to others (current and history); protective factors; action taken

Mental status observations
Appearance, speech, mood, affect, thought process, insight, judgment

Strengths, supports & measures
Coping, supports, motivation; baseline scores (e.g., PHQ-9, GAD-7)

Initial impression
Provisional diagnosis with rule-outs, tied to the symptoms documented above

Initial plan
Goals, modality, frequency, referrals, next appointment

Consent reviewed and signed: Y / N | Clinician signature / credentials: | Date signed: