

Intake Note Example & Documentation Checklist

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A compliant intake note summarizes the first session in eight components. Use this reference when writing, then check your note against the checklist on the last page before signing. Billing: CPT 90791 (therapists) or 90792 (prescribers), typically once per client per year; complete documentation within 24-72 hours.

The 8 components of an intake note

1. Session details

Date, exact start/stop time, place of service (telehealth: client location + HIPAA-compliant platform statement), client name + second identifier, provider name and credentials.

2. Presenting problem

Concerns in concise clinical language: onset, duration, severity, precipitating factors.

3. Relevant history

Mental health, medical, family, developmental, and substance use history, summarized to what informs treatment.

4. Risk assessment findings

SI, HI, and self-harm responses documented explicitly, even when the client denies all risk.

5. Mental status exam

Appearance, behavior, mood, affect, thought process and content, cognition, insight, judgment.

6. Diagnostic impressions

Working diagnoses with the specific DSM-5-TR criteria met and differentials ruled in or out.

7. Screening tool scores

PHQ-9, GAD-7, or other administered instruments, with clinical interpretation.

8. Treatment plan outline

Frequency, modality, initial goals, interventions, and the CPT code.

Therapy Intake Assessment Example

Fictional client, for illustration only. Sections follow the structure of a Mentalyc intake note: presentation, psychological, biological, and social factors, clinical assessment, MSE, risk, strengths, goals, and plan.

Client

John Doe | DOB 05/17/1977

Consent

Therapist reviewed confidentiality and its limits, payment procedures, and client rights. John asked clarifying questions and agreed to proceed; signed informed consent on file.

Presentation (Chief Complaint)

Reports depressed mood for six months: persistent low mood, anhedonia, poor concentration at work, fatigue, early-morning insomnia, and feelings of worthlessness. Gradual worsening without a clear precipitating event. Impairments: reduced work performance, withdrawal from family activities and hobbies.

Psychological Factors

No prior diagnoses; no previous psychotherapy or psychiatric medication trials. Family mental health history: mother has a history of depression (treated); no other reported conditions in first-degree relatives.

Biological Factors

Hypertension, managed with medication. No other chronic conditions or recent hospitalizations. Sleep: early-morning waking, about 5 hours per night. Substances: two to three beers about twice weekly; denies tobacco, cannabis, other substances; no binge pattern. AUDIT not indicated at reported use level.

Social Factors

Married, two children, employed full-time. Family described as supportive; reports withdrawing from family time and previously enjoyed activities over the past six months.

Clinical Assessment

Consistent with Major Depressive Disorder, single episode, moderate (DSM-5-TR 296.22 / ICD-10 F32.1); 6 of 9 criteria met. Differentials: adjustment disorder with depressed mood (ruled out: duration over six months, no identifiable stressor); depression secondary to medical condition (hypertension managed, onset does not correlate; monitoring).

Mental Status Exam

Well groomed; cooperative. Mood depressed, affect congruent and constricted. Speech normal in rate and tone. Thought process linear and goal-directed; no delusions, obsessions, or perceptual disturbances. Oriented x4. Cognition grossly intact. Insight and judgment fair.

Risk Assessment

Denies current or past SI, self-harm, or HI. No access-to-means concerns. No safety plan required at this time.

Strengths and Resources

Motivated and help-seeking; supportive spouse and close family; stable employment.

Discussed Goals

Wants to "feel like himself again" and regain interest in daily activities, hobbies, and family time. Progress measured by PHQ-9 reduction and weekly count of engaged activities.

Follow-Up and Plan

Weekly individual CBT. Goals: (1) reduce depressive symptoms per PHQ-9 baseline at next session, (2) behavioral activation for engagement, (3) structured sleep intervention. Re-administer PHQ-9 in four weeks; reassess plan in 4-6 sessions.

Intake Documentation Checklist

Run through this before signing the note.

- Client demographics and a second identifier recorded
- Session details: date, start/stop time, place of service (telehealth statement if applicable)
- Informed consent and confidentiality limits explained and signed
- Presenting problem: onset, duration, severity, precipitating factors
- Mental health history: prior diagnoses, treatments, hospitalizations
- Medical history: conditions, medications, sleep, appetite
- Family history: mental health, substance use, medical conditions
- Developmental history: milestones, early experiences, trauma
- Substance use screened: type, frequency, amount, consequences
- Risk assessment documented (SI, HI, self-harm), even if all denied; safety plan if indicated
- Cultural and identity factors noted
- Mental status exam completed across all domains
- Screening scores recorded with interpretation (PHQ-9, GAD-7, others as indicated)
- Diagnostic impressions cite specific DSM-5-TR criteria and differentials
- Treatment plan: frequency, modality, initial goals, CPT code (90791/90792)
- Note written same day; signed with name and credentials

Mentalyc drafts the full intake note from your session. Try it free at mentalyc.com/ai-note-taker