Intake, Treatment Plan & Discharge Templates

The three documents either side of your progress notes — blank and guided, print-ready, for private practice.

What's inside

- Intake / initial assessment — two blank pages plus a guided version
- Treatment plan — goals, objectives, interventions and review dates
- Discharge summary — course of treatment, outcome and aftercare
- The golden thread — how all four documents connect, and where the connection usually breaks

This is pack two

Pack one covers the progress notes that sit between intake and discharge — blank and guided SOAP, DAP and BIRP templates, plus a ten-question self-audit. It's free at digitalinz.com/progress-note-templates-private-practice

Intake — blank (1 of 2)

Identifying information, presenting problem and history.

1 Presenting problem in the client's words

2 History of presenting problem onset, course, triggers

3 Relevant history psychiatric, medical, family, social

4 Current medications & providers with prescriber

Intake — blank (2 of 2)

Mental status, risk, formulation and initial plan.

5 Mental status examination

appearance, speech, affect, cognition

6 Risk assessment

ideation, plan, intent, means, history, protective

7 Diagnostic impression

with supporting rationale

8 Initial plan

modality, frequency, goals, review point

Clinician _____ Client ID _____ Date _____

Intake — guided

Answer the prompts in prose. The aim is a document that justifies the treatment plan that follows it.

Presenting problem

- ☐ What brought them in, in their own words?
- ☐ Why now? What changed recently?
- ☐ How is this affecting work, relationships, daily functioning?

History

- ☐ When did this start, and what was happening then?
- ☐ Has it happened before? What helped, what didn't?
- ☐ Previous treatment, including what ended it?
- ☐ Family history of mental health concerns?
- ☐ Substance use — current pattern, not just presence?

Mental status

- ☐ Appearance, grooming, behaviour during the session?
- ☐ Speech, affect, mood, thought process and content?

Risk

- ☐ Suicidal ideation — asked directly, and the answer recorded?
- ☐ Plan, intent, means, preparatory behaviour?
- ☐ History of attempts or self-harm?
- ☐ Homicidal ideation, and any safeguarding concerns?
- ☐ Protective factors — ideally client-generated?

Formulation and plan

- ☐ What is your diagnostic impression, and what supports it?
- ☐ What is maintaining the problem now?
- ☐ Modality, frequency, expected duration and review point?
- ☐ What are the two or three treatment goals, in the client's terms?

Treatment plan — blank

Two or three goals is usually right. More than four rarely gets worked.

G1 **Goal 1** in the client's language

O1 **Objectives & interventions** measurable, with target date

G2 **Goal 2** in the client's language

O2 **Objectives & interventions** measurable, with target date

G3 **Goal 3** optional

O3 **Objectives & interventions** measurable, with target date

Clinician _____ Client ID _____ Date _____

Treatment plan — guided

The test of a treatment plan: could you write a progress note against it every week without rereading it?

For each goal

- ☐ Is it in the client's words, not clinical shorthand?
- ☐ Would the client recognise it as what they came for?
- ☐ Is it achievable in the time you actually have?

For each objective

- ☐ Is it measurable — frequency, duration, a score, an observable?
- ☐ Does it have a target date?
- ☐ Would two clinicians agree on whether it had been met?

For each intervention

- ☐ Is the modality named, not just "therapy"?
- ☐ Does it plausibly produce the objective above it?
- ☐ Is it within your scope and training?

Review

- ☐ When will this plan be formally reviewed?
- ☐ What would tell you the plan is wrong rather than the client is stuck?
- ☐ Has the client been involved in writing it, and does the record show that?

Discharge summary — blank

Complete within your required timeframe, planned ending or not.

1 Dates & episode

first session, last session, number attended

2 Presenting problem & diagnosis

at intake and at discharge

3 Course of treatment

modality, interventions, response

4 Outcome

goals met, partially met, not met — with evidence

5 Reason for discharge & aftercare

including risk at discharge

Clinician _____ Client ID _____ Date _____

Discharge summary — guided

Write it so that a clinician picking this client up in three years knows what happened and what worked.

Course of treatment

- ☐ How many sessions, over what period, and how many missed?
- ☐ What modality and which specific interventions?
- ☐ What did the client respond to, and what didn't land?

Outcome

- ☐ Which goals were met, partially met, or not met?
- ☐ What evidence supports that — scores, behaviour, report?
- ☐ Diagnosis at discharge, and any change from intake?

Ending

- ☐ Planned, client-initiated, or lost to contact? Say which.
- ☐ If unplanned, what outreach was attempted and documented?
- ☐ Risk status at the final contact, asked and recorded?

Aftercare

- ☐ Referrals made, and to whom?
- ☐ Relapse-prevention plan provided?
- ☐ Does the client know how to return, and is that documented?
- ☐ Records to be copied to anyone, and is consent on file?

The golden thread

The four documents are supposed to be one argument told in four parts. This is what auditors are checking when they pull a chart, and it is where private practice documentation most often falls down.

Intake establishes the problem.

It says what is wrong, what is maintaining it, and why treatment is warranted. Everything downstream has to be traceable back to it.

The treatment plan turns that into targets.

Goals come from the presenting problem. Objectives make them measurable. Interventions are chosen because they plausibly produce the objectives.

Progress notes evidence movement against those targets.

This is the link that breaks most often. If your Assessment section never references a treatment plan goal, the thread is cut — and a reviewer reading the chart cannot tell whether the sessions were treatment or conversation.

Discharge closes the loop.

It states which goals were met and on what evidence, which is only possible if the three documents above it were written to connect.

The one-minute chart test

- ☐ Open a treatment plan goal. Can you find it named in the last three progress notes?
- ☐ Open a progress note Assessment. Does it reference progress toward a stated goal?
- ☐ Open a discharge summary. Can you trace each outcome claim to notes that evidence it?

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