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**Case Notes Checklist for Social Work & Case Management**

Use this interactive checklist to ensure your SOAP, DAP, BIRP, and GIRP notes are clear, complete, and aligned with best practices. Tick off each box as you include each element in your case notes.

# SOAP Notes Checklist

**☐** Include the client’s reported concerns, feelings, or quotes (Subjective)

**☐** Note observable behaviors and measurable facts (Objective)

**☐** Write a professional clinical interpretation (Assessment)

**☐** Document the plan: next steps, referrals, or goals (Plan)

**☐** Add date, time, and session type (in-person, phone, etc.)

**☐** Ensure use of professional, non-judgmental language

# DAP Notes Checklist

**☐** Combine client’s report and observations (Data)

**☐** Summarize key insights and clinical interpretation (Assessment)

**☐** List next steps or referrals based on the session (Plan)

**☐** Avoid generic terms—keep the content client-specific

**☐** Follow agency formatting and terminology guidelines

# BIRP Notes Checklist

**☐** Document what the client said or did (Behavior)

**☐** Describe your intervention or method used (Intervention)

**☐** Explain how the client responded (Response)

**☐** Write out future plans or session goals (Plan)

**☐** Ensure consistency in language for audits or insurance billing

# GIRP Notes Checklist

**☐** Link note to client’s goal or treatment plan (Goal)

**☐** Describe how you supported that goal (Intervention)

**☐** Note the client’s feedback or engagement (Response)

**☐** Outline the next steps or follow-up plan (Plan)

**☐** Use goal-centered, action-oriented language

# General Documentation Reminders

**☐** Always include date, time, and type of session

**☐** Avoid assumptions—stay objective and clear

**☐** Use consistent formatting for every note

**☐** Proofread for clarity, spelling, and grammar

**☐** Ensure someone unfamiliar with the case can understand the note

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