

Pediatric SOAP note example

Claire · Educational resource · Approved by Dr. Ian Taylor, October 1, 2026

A fictional pediatric SOAP note example that separates caregiver report, child participation, observed findings, developmental surveillance, assessment, and follow-up.

Clinical boundary

This example does not replace age-specific assessment, validated screening tools, dosing verification, safeguarding procedures, emergency evaluation, or local consent and confidentiality requirements.

Fictional SOAP example

Subjective

Fictional caregiver reports concern that a preschool-aged child uses fewer spontaneous phrases than expected by the family. The caregiver describes gradual progress and no reported loss of previously acquired skills.

The child participates briefly in the history. Sleep, feeding, hearing concerns, social interaction, and the language environment are documented only as reported during this fictional encounter.

Objective

Age, source of history, vital signs, growth measurements, and the date and source of each value are recorded. The clinician documents observed communication, play, interaction, and the focused physical examination without prefilled normal findings.

If a standardized instrument is used, its exact name, score, interpretation, and limitations belong in the record. Developmental surveillance alone is not labelled as a completed validated screen.

Assessment

Caregiver concern regarding expressive language development, with continued progress reported and no reported regression. The available history and observation warrant clinician interpretation and may identify the need for a validated screen or further evaluation.

The example does not assign a developmental diagnosis. Hearing, multilingual exposure, broader development, family history, and functional impact remain relevant to the patient-specific assessment.

Plan

Document the clinician's age-specific screening, referral, follow-up, family guidance, and safety decisions after the complete encounter.

Record the responsible person, timing, and contingency for each follow-up item, including how results will be reviewed.

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Age, visit type, and information sources

Caregiver concern and child participation

Developmental history and function

Growth measures with source and date

Observed behavior and focused examination

Surveillance versus validated screening

Assessment with uncertainty

Referral, follow-up, results ownership, and contingencies

Review checklist

- Historian, age, and confidentiality context
- Growth-measure source, units, and date
- Surveillance separated from validated screening
- Named owner and timing for referrals or pending results

Sources consulted

NCBI Bookshelf, SOAP Notes: <https://www.ncbi.nlm.nih.gov/books/NBK482263/>

AAFP, Writing Clinical Notes: Have We Made Progress?: <https://www.aafp.org/fpm/2022/0700/writing-clinical-notes>

AAP, Developmental Surveillance and Screening:

https://publications.aap.org/pediatrics/article-pdf/145/1/e20193449/1074887/peds_20193449.pdf

CDC, Evidence-Informed Milestones for Developmental Surveillance Tools:

https://stacks.cdc.gov/view/cdc/122643/cdc_122643_DS1.pdf