

NEUROLOGICAL SCREENING PRACTICE TEST (SAMPLE)

STUDY GUIDE



SAMPLE STUDY GUIDE WITH LIMITED QUESTIONS

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Introduction

Preparing for a certification exam can feel overwhelming, but with the right tools, it becomes an opportunity to build confidence, sharpen your skills, and move one step closer to your goals. At Examzify, we believe that effective exam preparation isn't just about memorization, it's about understanding the material, identifying knowledge gaps, and building the test-taking strategies that lead to success.

This guide was designed to help you do exactly that.

Whether you're preparing for a licensing exam, professional certification, or entry-level qualification, this book offers structured practice to reinforce key concepts. You'll find a wide range of multiple-choice questions, each followed by clear explanations to help you understand not just the right answer, but why it's correct.

The content in this guide is based on real-world exam objectives and aligned with the types of questions and topics commonly found on official tests. It's ideal for learners who want to:

- Practice answering questions under realistic conditions,
- Improve accuracy and speed,
- Review explanations to strengthen weak areas, and
- Approach the exam with greater confidence.

We recommend using this book not as a stand-alone study tool, but alongside other resources like flashcards, textbooks, or hands-on training. For best results, we recommend working through each question, reflecting on the explanation provided, and revisiting the topics that challenge you most.

Remember: successful test preparation isn't about getting every question right the first time, it's about learning from your mistakes and improving over time. Stay focused, trust the process, and know that every page you turn brings you closer to success.

Let's begin.

How to Use This Guide

This guide is designed to help you study more effectively and approach your exam with confidence. Whether you're reviewing for the first time or doing a final refresh, here's how to get the most out of your Examzify study guide:

1. Start with a Diagnostic Review

Skim through the questions to get a sense of what you know and what you need to focus on. Your goal is to identify knowledge gaps early.

2. Study in Short, Focused Sessions

Break your study time into manageable blocks (e.g. 30 – 45 minutes). Review a handful of questions, reflect on the explanations.

3. Learn from the Explanations

After answering a question, always read the explanation, even if you got it right. It reinforces key points, corrects misunderstandings, and teaches subtle distinctions between similar answers.

4. Track Your Progress

Use bookmarks or notes (if reading digitally) to mark difficult questions. Revisit these regularly and track improvements over time.

5. Simulate the Real Exam

Once you're comfortable, try taking a full set of questions without pausing. Set a timer and simulate test-day conditions to build confidence and time management skills.

6. Repeat and Review

Don't just study once, repetition builds retention. Re-attempt questions after a few days and revisit explanations to reinforce learning. Pair this guide with other Examzify tools like flashcards, and digital practice tests to strengthen your preparation across formats.

There's no single right way to study, but consistent, thoughtful effort always wins. Use this guide flexibly, adapt the tips above to fit your pace and learning style. You've got this!

Questions

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- 1. Right homonymous hemianopia most consistent with a lesion in which location?**
 - A. Left retina
 - B. Right optic nerve
 - C. Bilateral chiasm
 - D. Left post-chiasmal visual pathway
- 2. The L1-L2 myotome action primarily tests which movement?**
 - A. Knee Extension
 - B. Hip Flexion
 - C. Ankle Dorsiflexion
 - D. Hip Abduction
- 3. What is the clock-drawing test used for in cognitive screening, and what would a poor performance indicate?**
 - A. It primarily assesses motor planning
 - B. It measures attention and short-term memory only
 - C. It is used to test language fluency
 - D. It assesses visuospatial and executive function; poor performance suggests cognitive impairment or dementia
- 4. Which findings suggest a trigeminal nerve (CN V) lesion during facial sensation testing?**
 - A. Normal sensation in V1-V3
 - B. Reduced sensation in V1-V3, facial weakness, or loss of corneal reflex
 - C. Increased sensation in V2
 - D. Loss of taste on the anterior tongue
- 5. Which components are part of a bedside mental status examination?**
 - A. Appearance, behavior, attention, orientation, memory, language, and thought
 - B. Mood, affect, gait, balance
 - C. Hair color, height, weight, blood pressure
 - D. Vision, hearing, taste, smell

6. C7 deep tendon reflexes test which muscle?

- A. Biceps Brachii
- B. Brachioradialis
- C. Wrist Extensors
- D. Triceps Brachii

7. Wernicke's aphasia is best described by which bedside finding?

- A. Nonfluent speech with relatively preserved comprehension
- B. Fluent speech with nonsensical content and poor comprehension
- C. Nonfluent speech with poor repetition
- D. Fluent speech with preserved comprehension

8. Which statement accurately describes the difference between primary sensory loss and cortical sensory loss?

- A. Primary sensory loss affects basic modalities in a dermatomal pattern; cortical sensory loss affects localization and higher-order processing
- B. Primary sensory loss affects only smell; cortical sensory loss affects only vision
- C. Cortical sensory loss affects reflexes
- D. Primary sensory loss is not testable clinically

9. Which feature is typical of a spinal cord lesion?

- A. Deficits spanning multiple segments with a defined sensory level
- B. Visual field defect
- C. Isolated cranial nerve palsy
- D. Weakness and sensory loss below a defined level with preserved cranial nerves

10. Which set of intrinsic hand muscles is innervated by the ulnar nerve at the wrist?

- A. Abductor/opponens/flexor digiti minimi, lumbricals III and IV, interossei, adductor pollicis, flexor pollicis brevis (deep head)
- B. Abductor pollicis longus; Extensor pollicis longus; Lumbricals I-II
- C. Abductor pollicis brevis; Opponens pollicis; Flexor pollicis longus; Interossei
- D. Flexor digitorum superficialis; Flexor digitorum profundus; Interossei; Adductor pollicis

Answers

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1. D
2. B
3. D
4. B
5. A
6. D
7. B
8. A
9. D
10. A

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Explanations

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1. Right homonymous hemianopia most consistent with a lesion in which location?

- A. Left retina
- B. Right optic nerve
- C. Bilateral chiasm

D. Left post-chiasmal visual pathway

The key idea is how visual field defects map to different parts of the visual pathway. Lesions after the optic chiasm produce homonymous field loss (the same side of the visual field in both eyes), whereas lesions before the chiasm cause monocular loss, and lesions at the chiasm typically cause bitemporal loss. A right homonymous hemianopia means the right half of the visual field is lost in both eyes. That pattern points to a lesion on the left side of the post-chiasmal visual pathway—think left optic radiations or left occipital cortex. The left post-chiasmal pathway is responsible for conveying information from the right visual field of both eyes, so a lesion there yields this exact deficit. The other options don't fit the pattern: a left retina or a right optic nerve lesion would cause vision loss in only one eye (monocular), not in the right visual field of both eyes; a bilateral chiasm lesion would produce bitemporal hemianopia, not a right-sided hemianopia.

2. The L1-L2 myotome action primarily tests which movement?

- A. Knee Extension
- B. Hip Flexion**
- C. Ankle Dorsiflexion
- D. Hip Abduction

Hip flexion is tested because the iliopsoas muscle group, responsible for lifting the thigh toward the abdomen, is primarily innervated by the L1-L2 nerve roots. When you assess this movement, you're evaluating the function of those roots; weakness or pain here points to L1-L2 involvement. For contrast, knee extension relies on the quadriceps (L3-L4), ankle dorsiflexion on the tibialis anterior (L4-L5), and hip abduction on the gluteal muscles (usually L4-S1), which is why those motions map to other myotomes.

3. What is the clock-drawing test used for in cognitive screening, and what would a poor performance indicate?

- A. It primarily assesses motor planning
- B. It measures attention and short-term memory only
- C. It is used to test language fluency
- D. It assesses visuospatial and executive function; poor performance suggests cognitive impairment or dementia**

Visuospatial processing and executive function are what this task targets. To perform it well, a person must understand the instruction, picture a clock face, place the numbers in their correct positions around the circle, and set the hands to a specified time. This requires organizing spatial relationships, sequencing, and the motor skills to draw. A poor performance points to difficulties in these domains, which are commonly affected in cognitive decline and dementia. Keep in mind it's a quick screening tool, so a low score flags the need for more thorough evaluation, and results can be influenced by education, culture, vision, or motor problems.

4. Which findings suggest a trigeminal nerve (CN V) lesion during facial sensation testing?

- A. Normal sensation in V1-V3
- B. Reduced sensation in V1-V3, facial weakness, or loss of corneal reflex**
- C. Increased sensation in V2
- D. Loss of taste on the anterior tongue

The trigeminal nerve provides facial sensation via three divisions (V1, V2, V3), and it also has motor fibers for jaw muscles. A lesion typically shows decreased or abnormal sensation in the regions supplied by those divisions, so you'd expect reduced sensory input in V1-V3 during facial sensation testing. If the motor portion is involved (V3), you might also see facial weakness related to muscles of mastication. Loss of the corneal reflex further supports CN V involvement because the corneal blink reflex relies on CN V to sense the touch and CN VII to trigger the response; if the afferent limb is impaired, the reflex is diminished or absent. In contrast, normal sensation in V1-V3, or increased sensation in V2, doesn't fit a CN V lesion, and loss of taste on the anterior tongue points to CN VII rather than CN V. So reduced sensation in the three divisions, with possible corneal reflex loss or facial weakness, best indicates a trigeminal nerve lesion.

5. Which components are part of a bedside mental status examination?

- A. Appearance, behavior, attention, orientation, memory, language, and thought**
- B. Mood, affect, gait, balance
- C. Hair color, height, weight, blood pressure
- D. Vision, hearing, taste, smell

The bedside mental status exam is a quick snapshot of a patient's current cognitive and emotional state, assessed through how they look and act, and through simple tests of thinking and awareness. The components that fit this exam well are appearance and behavior (what you observe about how they present and respond), attention (how well they can concentrate), orientation (awareness of person, time, and place), memory (ability to recall recent and/or past information), language (naming, repetition, comprehension), and thought (how ideas are formed and expressed, including coherence). Together, these domains give a practical picture of brain function at the bedside and help identify delirium, dementia, mood disorders, or other acute brain issues. The other options pull in areas not central to the mental status snapshot. Gait and balance are motor findings, not cognitive or emotional status. Hair color, height, weight, and blood pressure are physical measurements, not cognitive or behavioral data. Vision, hearing, taste, and smell are sensory functions, which aren't the focus of the bedside mental status exam.

6. C7 deep tendon reflexes test which muscle?

- A. Biceps Brachii
- B. Brachioradialis
- C. Wrist Extensors
- D. Triceps Brachii**

Deep tendon reflex testing links a specific reflex to the spinal nerve roots that contribute to the involved muscle. The triceps brachii reflex is driven mainly by the C7 (and C8) nerve roots via the radial nerve. When you tap the triceps tendon just above the elbow with the forearm flexed and supported, a quick stretch signal travels to the spinal cord and causes a brisk contraction of the triceps, producing elbow extension. That makes the triceps the muscle tested by a C7 reflex. For context, other common reflexes map to different roots: the biceps reflex to C5-C6, the brachioradialis to C5-C6, and the wrist extensors to C6-C7.

7. Wernicke's aphasia is best described by which bedside finding?

- A. Nonfluent speech with relatively preserved comprehension
- B. Fluent speech with nonsensical content and poor comprehension**
- C. Nonfluent speech with poor repetition
- D. Fluent speech with preserved comprehension

Wernicke's aphasia is a receptive language disorder. When this area in the dominant hemisphere is damaged, speech tends to be fluent in rate and rhythm, but the content doesn't make sense because comprehension is impaired and word retrieval is disrupted. People may string together words that sound normal but are paraphasic or use invented words, and they often don't realize their speech is nonsensical. Repetition is also affected because the ability to understand and reproduce language is compromised. That bedside picture—speech that flows with nonsensical content and poor understanding—best fits Wernicke's aphasia. The other patterns point to different types: nonfluent speech with relatively preserved comprehension is typical of Broca's aphasia; nonfluent speech with poor repetition can occur in Broca or global aphasia; fluent speech with preserved comprehension would not be Wernicke's.

8. Which statement accurately describes the difference between primary sensory loss and cortical sensory loss?

- A. Primary sensory loss affects basic modalities in a dermatomal pattern; cortical sensory loss affects localization and higher-order processing**
- B. Primary sensory loss affects only smell; cortical sensory loss affects only vision
- C. Cortical sensory loss affects reflexes
- D. Primary sensory loss is not testable clinically

The key idea is distinguishing where the sensory problem lies: basic sensation versus higher order interpretation. When a lesion affects the primary somatosensory pathways (like peripheral nerves, dorsal columns, thalamus, or brainstem), basic modalities such as pain, temperature, touch, and proprioception are lost in a dermatomal or tract specific pattern. In contrast, cortical sensory loss comes from damage to the sensory cortex (often the parietal lobe) and shows impaired interpretation of sensation—difficulty localizing where a touch occurred, recognizing objects by touch (stereognosis), or identifying leaves of writing on the skin (graphesthesia). The deficit isn't just a simple body map loss; it reflects higher level processing problems. That's why this statement is best: it captures the distinction between losing basic sensory input in a predictable body map versus losing the brain's ability to interpret and localize those inputs. The other ideas don't fit because they misstate what is affected or how it's tested clinically—for example, smell or vision aren't the dichotomy here; reflexes are not the defining feature of the two types; and primary sensory loss can be detected with standard bedside tests.

9. Which feature is typical of a spinal cord lesion?

- A. Deficits spanning multiple segments with a defined sensory level
- B. Visual field defect
- C. Isolated cranial nerve palsy
- D. Weakness and sensory loss below a defined level with preserved cranial nerves**

When a spinal cord lesion is present, the deficits that arise affect both motor and sensory function below the level of the injury, producing a clear boundary or sensory level. The cranial nerves, which originate above the spinal cord, remain intact. So you see weakness and sensory loss starting at a defined trunk level and continuing downward, while cranial nerve function is preserved. This pattern helps distinguish a spinal cord problem from brainstem or cortical lesions (which would affect cranial nerves or visual pathways) or peripheral nerve disorders (which may not produce a clean, level-defined boundary).

10. Which set of intrinsic hand muscles is innervated by the ulnar nerve at the wrist?

- A. Abductor/opponens/flexor digiti minimi, lumbricals III and IV, interossei, adductor pollicis, flexor pollicis brevis (deep head)**
- B. Abductor pollicis longus; Extensor pollicis longus; Lumbricals I-II
- C. Abductor pollicis brevis; Opponens pollicis; Flexor pollicis longus; Interossei
- D. Flexor digitorum superficialis; Flexor digitorum profundus; Interossei; Adductor pollicis

The muscles innervated by the ulnar nerve at the wrist are the intrinsic hand muscles that form the ulnar or medial side of the hand: the hypothenar muscles (abductor digiti minimi, flexor digiti minimi brevis, opponens digiti minimi), the interossei (palmar and dorsal), the adductor pollicis, the deep head of the flexor pollicis brevis, and the medial two lumbricals (lumbricals III and IV). These are all controlled by the ulnar nerve when it passes through the hand, after the median nerve has already supplied the thenar muscles and the lateral two lumbricals. So the best choice includes those exact muscles: the hypothenar group, interossei, adductor pollicis, deep head of flexor pollicis brevis, and lumbricals III–IV. The other options mix in muscles innervated by the median or radial nerves (such as the thenar muscles like abductor pollicis brevis and opponens pollicis, or extrinsic forearm muscles like abductor pollicis longus and extensor pollicis longus), or include the first two lumbricals which are median-nerve as well.

Next Steps

Congratulations on reaching the final section of this guide. You've taken a meaningful step toward passing your certification exam and advancing your career.

As you continue preparing, remember that consistent practice, review, and self-reflection are key to success. Make time to revisit difficult topics, simulate exam conditions, and track your progress along the way.

If you need help, have suggestions, or want to share feedback, we'd love to hear from you. Reach out to our team at hello@examzify.com.

Or visit your dedicated course page for more study tools and resources:

<https://neurologicalscreening.examzify.com>

We wish you the very best on your exam journey. You've got this!

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