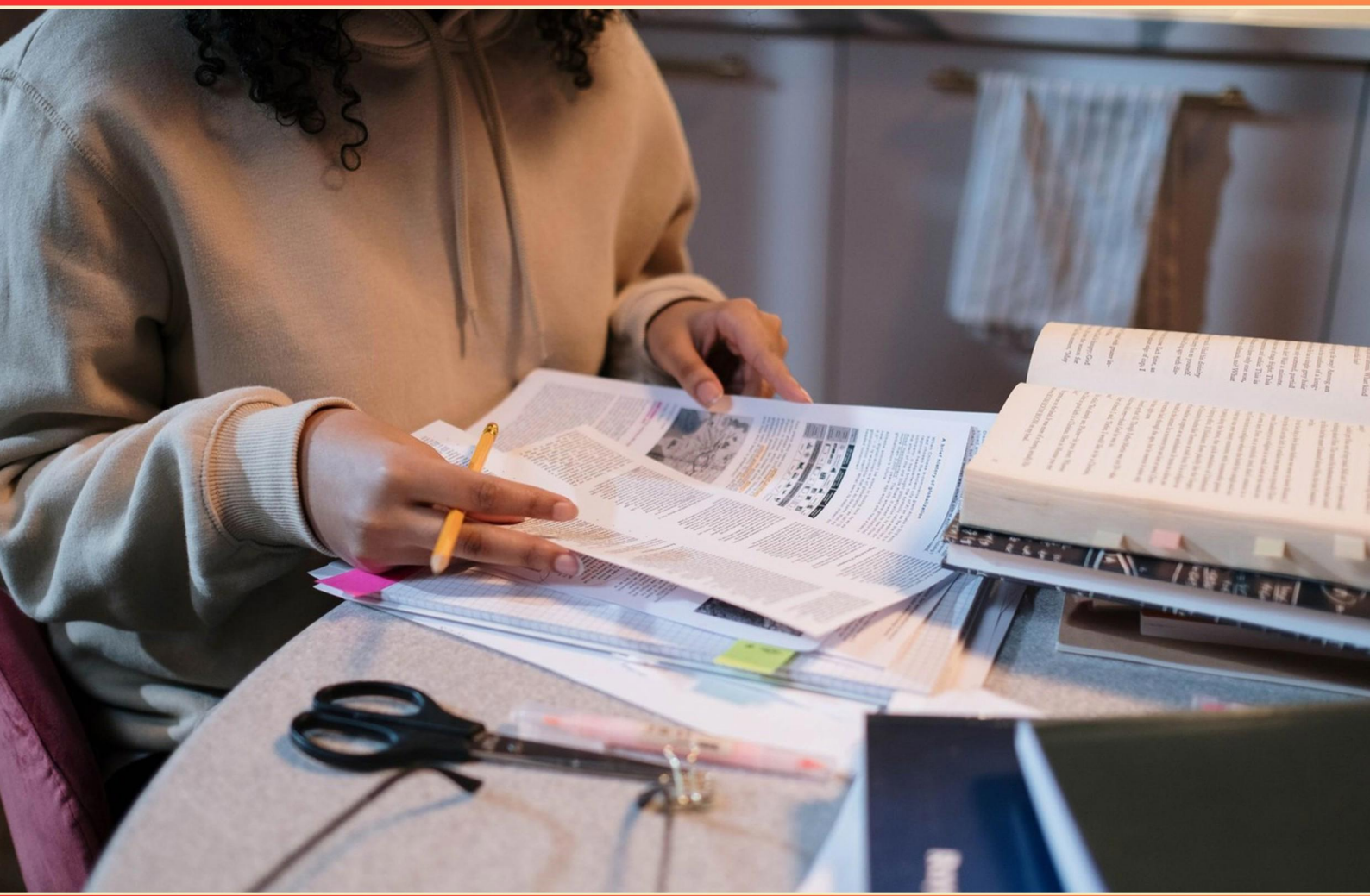
PTTM EXAM 1 PRACTICE (SAMPLE)

STUDY GUIDE



SAMPLE STUDY GUIDE WITH LIMITED QUESTIONS

VISIT US ONLINE FOR THE FULL VERSION STUDY GUIDE

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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.

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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!

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Questions

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1. What is the AAOS normative end feel and ROM for cervical flexion/extension?

A. 0-60 degrees; Firm

B. 0-45 degrees; Firm

C. 0-45 degrees; Soft

D. 0-90 degrees; Firm

2. What is a primary purpose of performing tests and measures in physical therapy?

A. Replace clinical reasoning

B. Confirm diagnosis

C. Eliminate baseline data

D. Predict exact recovery time

3. For measuring hip internal/external rotation with a goniometer, which combination correctly describes the patient position, stabilization, and fulcrum placement?

A. Position: Seated; Stabilize: Distal end femur to prevent abduction, adduction, or further hip flexion; Fulcrum: anterior aspect of patella; Stationary Arm: perpendicular to floor or parallel to supporting surface; Moving Arm: anterior midline of lower leg using the crest of tibia and point between malleoli for reference

B. Position: Supine; Stabilize: Pelvis; Fulcrum: medial malleolus; Stationary Arm: along midline of tibia; Moving Arm: along midline of foot

C. Position: Seated; Stabilize: Proximal thigh to prevent rotation; Fulcrum: posterior aspect of patella; Stationary Arm: along the longitudinal axis of the femur; Moving Arm: along the anterior midline of the lower leg

D. Position: Standing; Stabilize: Pelvis; Fulcrum: anterior superior iliac spine; Stationary Arm: along the thigh; Moving Arm: along the leg

4. The C2 dermatome corresponds to which region?

A. Supraclavicular fossa

B. Upper trapezius

C. Medial antecubital fossa

D. Suboccipital

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5. Which dermatome level corresponds to the dorsal/palmar surface of the thumb?

A. C5

B. C6

C. C4

D. C7

6. What is the AAOS normative end feel and range for shoulder internal rotation?

A. 0-70 degrees Firm

B. 0-60 degrees Firm

C. 0-70 degrees Hard

D. 0-75 degrees Firm

7. What is the AAOS normative end feel for knee flexion?

A. Soft (may see firm if tension on anterior capsule)

B. Firm

C. Hard

D. Empty

8. Which myotome maps to elbow extension and wrist flexion?

A. C6

B. C5

C. C7

D. L3

9. Hip abduction/adduction ROM: which option correctly identifies the moving arm?

A. Midline of tibia

B. Midline of pelvis

C. Midline of femur

D. Dorsal midline of foot

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10. What is the normative ROM for thoracolumbar extension in degrees?

A. 0-25 degrees

B. 0-45 degrees

C. 0-15 degrees

D. 0-30 degrees

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Answers

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

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Explanations

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1. What is the AAOS normative end feel and ROM for cervical flexion/extension?

A. 0-60 degrees; Firm

B. 0-45 degrees; Firm

C. 0-45 degrees; Soft

D. 0-90 degrees; Firm

In evaluating the cervical spine, two things matter: how far you can move (range of motion) and what the end feel feels like at the limit. For flexion and extension, the normative ROM is about 0 to 45 degrees from the neutral position. The end feel for these movements is firmness—there's a springy resistance from the surrounding soft tissues and joint structures rather than a soft spongey give or a hard block. So the best match is 0-45 degrees with a firm end feel for both cervical flexion and extension.

2. What is a primary purpose of performing tests and measures in physical therapy?

A. Replace clinical reasoning

B. Confirm diagnosis

C. Eliminate baseline data

D. Predict exact recovery time

Tests and measures in physical therapy are used to collect objective data that confirm the clinician's working diagnosis and guide the plan of care. By quantifying impairments such as strength, range of motion, pain, and functional ability, the therapist verifies that the patient's presentation aligns with a specific problem and that the chosen interventions target the right tissue or system. This objective information supports clinical reasoning and helps track progress over time, while not replacing the clinician's judgment or dictating an exact recovery timeline. Hence, the primary purpose is to confirm the diagnosis and tailor the care plan accordingly.

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3. For measuring hip internal/external rotation with a goniometer, which combination correctly describes the patient position, stabilization, and fulcrum placement?

A. Position: Seated; Stabilize: Distal end femur to prevent abduction, adduction, or further hip flexion; Fulcrum: anterior aspect of patella; Stationary Arm: perpendicular to floor or parallel to supporting surface; Moving Arm: anterior midline of lower leg using the crest of tibia and point between malleoli for reference

B. Position: Supine; Stabilize: Pelvis; Fulcrum: medial malleolus; Stationary Arm: along midline of tibia; Moving Arm: along midline of foot

C. Position: Seated; Stabilize: Proximal thigh to prevent rotation; Fulcrum: posterior aspect of patella; Stationary Arm: along the longitudinal axis of the femur; Moving Arm: along the anterior midline of the lower leg

D. Position: Standing; Stabilize: Pelvis; Fulcrum: anterior superior iliac spine; Stationary Arm: along the thigh; Moving Arm: along the leg

The key idea is to isolate hip rotation when measuring with a goniometer by using a position and setup that minimize compensations from other joints. In seated hip rotation, you stabilize the thigh so the distal femur cannot move in abduction, adduction, or further hip flexion, which keeps the motion coming from the hip joint itself. Placing the goniometer's axis at the anterior aspect of the patella lines up with the hip's rotation axis, ensuring the measurement reflects turning of the thigh around the hip. The stationary arm is kept perpendicular to the floor to provide a stable reference, while the moving arm follows the anterior midline of the lower leg along the tibial crest toward a reference between the malleoli, so the arc of rotation is tracked along the leg as it turns. This combination is preferred because it uses a reliable, consistent axis (patellar anterior point) and a stable framework (distal thigh stabilization and a vertical stationary arm) to measure pure hip rotation. Other setups place the fulcrum in less appropriate locations or allow additional movements (like pelvis or knee motion) that can contaminate the reading, or use a stance (standing) that makes isolation of hip rotation more difficult.

4. The C2 dermatome corresponds to which region?

A. Supraclavicular fossa

B. Upper trapezius

C. Medial antecubital fossa

D. Suboccipital

Dermatomes map skin areas to a single spinal nerve root. For the cervical nerves, the C2 dermatome runs over the back of the head and the upper neck—the suboccipital region just under the occipital bone. That's why this area is described as suboccipital. The supraclavicular fossa is linked to C3–C4, the medial antecubital fossa to lower roots around T1, and the upper trapezius area to C3–C4. So the region that matches C2 is the suboccipital area.

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5. Which dermatome level corresponds to the dorsal/palmar surface of the thumb?

A. C5

B. C6

C. C4

D. C7

Dermatomes map skin sensation to specific spinal nerve roots, so testing where sensation is felt helps localize the level. The thumb, on both its dorsal and palmar surfaces, falls in the C6 dermatome. This means the C6 root supplies the skin of the thumb area, while more medial digits align with other levels (like C7 for the middle finger and C8 for the ring/little fingers). So sensation in the thumb is a direct cue to the C6 distribution; loss there would suggest a C6-related issue, whereas the other levels map to different parts of the hand.

6. What is the AAOS normative end feel and range for shoulder internal rotation?

A. 0-70 degrees Firm

B. 0-60 degrees Firm

C. 0-70 degrees Hard

D. 0-75 degrees Firm

Internal rotation of the shoulder, measured with the arm at the side, normally reaches about 0 to 70 degrees before the motion ends. The end feel is firm, not hard, because the movement is limited by the tight posterior capsule and glenohumeral ligaments, with soft tissue tension as you approach the limit. This combination—0 to 70 degrees with a firm end feel—matches the AAOS normative data. Options suggesting a shorter or longer range or a hard end feel don't align with these standard values.

7. What is the AAOS normative end feel for knee flexion?

A. Soft (may see firm if tension on anterior capsule)

B. Firm

C. Hard

D. Empty

The end feel for knee flexion in a healthy joint is soft tissue approximation. As you bend the knee, the back of the thigh and the calf come into contact, creating a cushiony, soft endpoint. This normal soft end feel reflects the natural give of soft tissues around the joint. If the anterior capsule or related anterior structures are tense, you may feel a firmer end feel because the joint's soft tissues can't yield as easily. In contrast, a hard end feel would be more typical of a bony block or joint surface contact (often seen with extension), and an empty end feel suggests pain or joint pathology rather than normal end feel.

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8. Which myotome maps to elbow extension and wrist flexion?

A. C6

B. C5

C. C7

D. L3

The key idea is how motor function maps to spinal nerve roots (myotomes). For elbow extension and wrist flexion, the strongest shared nerve root is C7. Elbow extension uses the triceps, which is innervated by the radial nerve with a major contribution from C7. Wrist flexion involves the wrist flexor muscles, which receive input that is dominantly C7 along with other roots, making C7 the common myotome for both movements. Other roots don't cover both actions as effectively: C6 is more tied to wrist extension and elbow flexion somewhat, while C5 and L3 map to other regions (shoulder and knee, respectively). So C7 best explains both elbow extension and wrist flexion.

9. Hip abduction/adduction ROM: which option correctly identifies the moving arm?

A. Midline of tibia

B. Midline of pelvis

C. Midline of femur

D. Dorsal midline of foot

When measuring hip abduction/adduction, you want to track how the thigh moves relative to the pelvis. The moving arm should follow the thigh's long axis, so aligning it with the midline of the femur gives the true angle at the hip joint as the leg moves away from or toward the midline. Using the midline of the tibia would reflect knee alignment, and the dorsal midline of the foot would reflect foot/ankle position, not hip motion. The midline of the pelvis can serve as a stable reference for the stationary arm, but it won't capture the thigh's movement. So the moving arm should be the midline of the femur.

10. What is the normative ROM for thoracolumbar extension in degrees?

A. 0-25 degrees

B. 0-45 degrees

C. 0-15 degrees

D. 0-30 degrees

The motion available in the thoracolumbar region during extension is limited by the anatomy of the spine and rib cage, so the typical amount of extension from neutral is modest. In healthy adults, the combined thoracic and lumbar extensor range is about 20–25 degrees, with 25 degrees commonly cited as the normative upper limit. That's why the best choice is the one that reflects approximately 25 degrees of extension. Values much higher than this (like 30–45 degrees) would exceed the usual norm for this region, and a much smaller value (like 15 degrees) would be below what is typically observed in a healthy population.

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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://pttm1.examzify.com

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

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