

ACTIVE CARE EXAM 2 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. Which method is primarily used to address spinal alignment issues including scoliosis?**
 - A. CARs
 - B. ELDOA method
 - C. neuro-mobilization
 - D. PAILs
- 2. What is part of the retrain aspect of evidence-inspired active care?**
 - A. neurodevelopment, block vs. random, load strategies (primary vs secondary load management)
 - B. Hold-relax, contract-relax, CRAC, PIR, MET and PFS
 - C. Spinal mobility and segmental stability
 - D. Discussion and education, protection and biofeedback
- 3. Which statement best describes the relationship between tightness and weakness?**
 - A. Tight muscles tend to weaken, and weak muscles tend to be tight, increasing internal friction-pressure-tension.
 - B. Tight muscles always lead to stronger performance.
 - C. Weak muscles cannot be tight.
 - D. There is no relationship between tightness and weakness.
- 4. Which type of pain is due to emotional distress, catastrophization, fear-avoidance beliefs and behaviors along with pain hypervigilance?**
 - A. Peripheral neurogenic
 - B. Central affective
 - C. Central cognitive
 - D. Central autonomic
- 5. Why do most MSK injuries happen in the first place?**
 - A. Inadequate sleep
 - B. Genetic predisposition
 - C. Training volume excess
 - D. Poor load management

- 6. What type of pain varies based on dynamic movement, load or speed?**
- A. Peripheral mechanical/inflammatory
 - B. Nociceptive pain
 - C. Central nociplastic pain
 - D. Peripheral ischemic pain
- 7. Which statement describes the knee osteoarthritis home exercise program process?**
- A. Use only rest and days off.
 - B. Focus solely on cardiovascular training.
 - C. Assess ROM, strength, functional goals; plan progressive strengthening and ROM with progression criteria.
 - D. Avoid any home exercise program.
- 8. Describe pincer palpation.**
- A. Digital examination for trigger points
 - B. Pincer grip where groups of muscles are rolled between digits to detect taut bands
 - C. Like plucking a guitar string
 - D. Firm compression against an underlying structure
- 9. Trigger points are defined as?**
- A. A hyperirritable spot in skeletal muscle that is associated with a hypersensitive palpable nodule in a taut band
 - B. A stiff, non-tender region of muscle
 - C. A tear in muscle fibers
 - D. A nerve entrapment point
- 10. Which modalities are generally considered safe and evidence-based for acute musculoskeletal injuries?**
- A. Only heat should be used for acute injuries.
 - B. Cryotherapy for acute inflammation; thermotherapy for pain relief; gentle electrical stimulation; manual therapy.
 - C. High-intensity modalities are best for acute injuries.
 - D. No modalities are recommended for acute injuries.

Answers

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

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Explanations

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1. Which method is primarily used to address spinal alignment issues including scoliosis?

- A. CARs
- B. ELDOA method**
- C. neuro-mobilization
- D. PAILs

Spinal alignment problems like scoliosis are best addressed by methods that specifically lengthen and decompress the spine at targeted segments to improve space and alignment. The ELDOA method uses precise, long-held postures that lengthen the spine and create a dedicated space at one spinal level. By guiding the spine into a position of neutral alignment and loading it through a controlled, lengthened posture, it can reduce asymmetrical forces, improve segmental spacing, and enhance proprioceptive cues that support a straighter posture. This focused, segment-by-segment approach is particularly relevant for scoliosis, where misalignment and uneven loading occur along the spine. Other approaches cited focus on different mechanisms—CARs aim for joint centering across various joints without isolating a spinal segment for decompression, neuro-mobilization targets nerve mobility rather than structural alignment, and PAILs emphasize end-range tissue loading for mobility rather than segment-specific spinal realignment.

2. What is part of the retrain aspect of evidence-inspired active care?

- A. neurodevelopment, block vs. random, load strategies (primary vs secondary load management)**
- B. Hold-relax, contract-relax, CRAC, PIR, MET and PFS
- C. Spinal mobility and segmental stability
- D. Discussion and education, protection and biofeedback

Retraining in evidence-inspired active care centers on re-educating movement through motor-learning principles. It uses a progression that helps the nervous system learn and control functional patterns. Neurodevelopmental sequencing guides how tasks are ordered—from simple to more complex—to build stable motor control. Block versus random practice reflects how practice structure influences learning: early on, block practice helps refine movement, while later, random practice improves retention and transfer to real-life tasks. Load strategies describe how to progressively challenge the movement system: primary load management focuses on task-specific demands, and secondary load management adds external resistance or perturbations as tolerance increases. Together, these elements shape how patients relearn movement and function. The other options emphasize techniques or aspects that aren't primarily about re-educating movement patterns: manual techniques target tissue or neuromuscular facilitation; emphasis on mobility and stability or on discussion and protection covers different parts of care or education rather than the retraining of movement itself.

3. Which statement best describes the relationship between tightness and weakness?

- A. Tight muscles tend to weaken, and weak muscles tend to be tight, increasing internal friction-pressure-tension.**
- B. Tight muscles always lead to stronger performance.
- C. Weak muscles cannot be tight.
- D. There is no relationship between tightness and weakness.

Tightness and weakness often go hand in hand and can feed into a cycle. When a muscle is chronically tight, its ability to produce force can be reduced because of altered length-tension properties, neural inhibition, and fatigue from constant overuse. That makes the muscle feel weaker. Conversely, a weak muscle is more likely to be recruited excessively to stabilize joints and control movement, which can keep it in a heightened state of tension or guarding. This combination increases internal stress within the tissues, leading to more friction, stiffness, and unwanted tension during activity. So the idea that tightness and weakness reinforce each other and contribute to ongoing functional strain is the best description. Tightness leading to stronger performance isn't accurate, since tightness generally restricts range of motion and efficiency. Saying there's no relationship ignores the well-documented interplay between length-tension, motor control, and tissue stress. And the notion that weak muscles can't be tight isn't true, because compensation and altered activation patterns can keep a weak muscle chronically tense.

4. Which type of pain is due to emotional distress, catastrophization, fear-avoidance beliefs and behaviors along with pain hypervigilance?

- A. Peripheral neurogenic
- B. Central affective**
- C. Central cognitive
- D. Central autonomic

Pain experience is shaped more by emotional and affective processing in the brain than by the peripheral sensation alone. When emotional distress, catastrophizing, fear-avoidance beliefs, and hypervigilance are present, they drive the affective-motivational dimension of pain, amplifying how pain is felt and sustained. This modulation happens through brain circuits in the limbic system and prefrontal areas that influence how threatening the pain feels and how much attention it receives, feeding a cycle where emotion and vigilance increase pain perception and distress. Peripheral nerve-origin pain would be driven by nerve pathology rather than emotional or cognitive factors. Central cognitive alone would focus on thoughts and beliefs without accounting for the strong emotional reactions that accompany pain and push the experience upward. Central autonomic would emphasize bodily arousal systems rather than the evaluative-emotional modulation of pain. Central affective best captures how emotional state and affective processing in the CNS shape the ongoing pain experience in conjunction with these behavioral responses.

5. Why do most MSK injuries happen in the first place?

- A. Inadequate sleep
- B. Genetic predisposition
- C. Training volume excess
- D. Poor load management**

Injury risk mainly comes from how training stress is managed over time. When the amount and intensity of work, plus how often you train, rise faster than the body's tissues can adapt and recover, microdamage accumulates and injuries occur. This is the essence of poor load management—not giving the body enough gradual progression, sufficient rest, or proper periodization to handle the demand. Training volume excess fits into this, as an insufficiently progressed or overly demanding program can overwhelm tissues, but it's a specific example of the broader load-management issue. Sleep and genetics can influence risk, but they're not the primary driver in most cases; sleep affects recovery and performance, and genetics can modulate susceptibility, yet the controllable factor that explains most injuries is how load is planned and recovered from.

6. What type of pain varies based on dynamic movement, load or speed?

- A. Peripheral mechanical/inflammatory**
- B. Nociceptive pain
- C. Central nociplastic pain
- D. Peripheral ischemic pain

Pain that shifts with dynamic movement, load, or speed points to tissue-driven mechanics. Peripheral mechanical/inflammatory pain arises when tissues—like muscles, ligaments, tendons, or joints—are loaded, stretched, compressed, or stressed during movement. This mechanical input directly activates mechanosensitive nociceptors, so the pain intensity can rise as you increase movement, weight, or speed. If inflammation is present, inflammatory mediators sensitize these nerves, amplifying pain with activity and loading. Nociceptive pain is a broad category tied to tissue damage but isn't defined by how movement or load modulates it. Central nociplastic pain involves altered brain processing with less direct tying to tissue mechanics, and peripheral ischemic pain centers on reduced blood flow, which is a different mechanism and pattern than movement- and load-dependent nociception.

7. Which statement describes the knee osteoarthritis home exercise program process?

- A. Use only rest and days off.
- B. Focus solely on cardiovascular training.
- C. Assess ROM, strength, functional goals; plan progressive strengthening and ROM with progression criteria.**
- D. Avoid any home exercise program.

Planning and progressing a knee osteoarthritis home exercise program involves evaluating what the knee can do and what functional goals the patient has, then designing a safe, progressive plan that blends strengthening with range-of-motion work. By assessing range of motion and muscle strength, you identify limitations and target areas (such as the quadriceps, hip abductors, and hamstrings) that support the knee. Incorporating functional goals—like easier stairs, steadier walking, or standing up from a chair—helps tailor the program to real daily needs. With this foundation, you set a plan that gradually increases strengthening and ROM, using clear progression criteria (for example, increasing resistance or reps when exercises are performed with good form and only mild or no increase in symptoms). This outcome-focused, progressive approach is essential for safely improving joint function and pain. Rest-only, cardio-only, or avoiding a home program don't provide this integrated, goal-driven progression that combines motion, strength, and functional outcomes, so they don't fit the best description of a knee OA home exercise program.

8. Describe pincer palpation.

- A. Digital examination for trigger points
- B. Pincer grip where groups of muscles are rolled between digits to detect taut bands**
- C. Like plucking a guitar string
- D. Firm compression against an underlying structure

Pincer palpation uses the pincer grip—thumb and index finger—to roll small portions of muscle tissue between the digits, gliding along the muscle fibers to feel for a tight, rope-like taut band and any nodules. This rolling, two-finger technique helps reveal localized hypertonicity and potential trigger points by assessing texture, fiber direction, and tenderness as you move along the muscle belly. It's different from pressing with a single finger, which is a point-contact examination; from plucking a guitar string, which suggests tapping or vibration rather than palpating tissue bands; and from firm compression against an underlying structure, which emphasizes compression rather than rolling to detect tissue texture.

9. Trigger points are defined as?

- A. A hyperirritable spot in skeletal muscle that is associated with a hypersensitive palpable nodule in a taut band
- B. A stiff, non-tender region of muscle
- C. A tear in muscle fibers
- D. A nerve entrapment point

Trigger points are hyperirritable spots within skeletal muscle that are associated with a hypersensitive palpable nodule in a taut band. Pressing on them often reproduces local pain and can trigger referred pain to distant areas, sometimes along predictable patterns, and may also affect muscle function. This combination of a tender spot plus a palpable knot within a tight band is what sets trigger points apart. That distinguishes them from a stiff, non-tender region of muscle, which lacks the tenderness and palpable nodule characteristic of trigger points. It also separates them from a tear in muscle fibers, which is an acute injury with tissue damage and different signs, and from a nerve entrapment point, which involves nerve compression and neuropathic pain patterns rather than a muscle knot within a taut band.

10. Which modalities are generally considered safe and evidence-based for acute musculoskeletal injuries?

- A. Only heat should be used for acute injuries.
- B. Cryotherapy for acute inflammation; thermotherapy for pain relief; gentle electrical stimulation; manual therapy.
- C. High-intensity modalities are best for acute injuries.
- D. No modalities are recommended for acute injuries.

In acute musculoskeletal injuries, the priority is to control inflammation and pain while preserving tissue function using safe, evidence-based approaches. Cryotherapy—applying cold—is used in the acute phase because it constricts blood vessels, lowers metabolic demand, reduces swelling, and dulls pain, helping to limit tissue damage from inflammation. As healing progresses and pain persists, thermotherapy can be used to help relax muscles, ease stiffness, and provide comfortable pain relief, recognizing that heat is typically avoided during the very first, most inflamed moments but can be beneficial later on. Gentle electrical stimulation, such as TENS, offers pain modulation without aggressive tissue loading and can aid comfort and function when used prudently. Manual therapy, delivered gently, helps maintain joint range of motion and soft-tissue mobility without stressing acutely damaged tissues. High-intensity modalities and aggressive treatments are not appropriate in the acute stage, and opting for no modalities misses evidence-supported options that can ease recovery.

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://activecare2.examzify.com>

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

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