

Introduction to EHR Palmer Practice Test (Sample)

Study Guide



Everything you need from our exam experts!

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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. _____ term goals are where you expect to be at the end of the care plan, with that end date stated.
 - A. Long
 - B. Short
 - C. Medium
 - D. Immediate

2. What is the primary focus of this week's lecture in the context of EHR? (week 3)
 - A. learning about patient billing codes
 - B. navigating the patient portal
 - C. learning about subjective and entering it into the EHR
 - D. data conversion from paper records

3. Which SOAP section describes the plan for future care?
 - A. Subjective
 - B. Objective
 - C. Assessment
 - D. Plan

4. Why is it important to document both the listing and the technique used in the adjustments?
 - A. To provide clarity on what was done and guide others who may cover or read the note
 - B. To ensure the patient understands the procedure
 - C. To fulfill random auditing requirements
 - D. To increase the number of characters in the note

5. How can you ensure you are working on the correct progress note in the EHR?
 - A. verify the clinician's initials
 - B. check the date and ensure it matches the date of service
 - C. confirm the patient's address
 - D. review the last login time

- 6. What is the primary purpose of the course taught by Dr. Jordahl?**
- A. To introduce students to electronic health records and provide the required patient documentation components**
 - B. To train clinicians in surgical procedures**
 - C. To teach billing and coding for reimbursement**
 - D. To study healthcare policy**
- 7. Which section of the SOAP note is used to record the clinician's direct observations during examination?**
- A. Objective**
 - B. Plan**
 - C. Assessment**
 - D. Subjective**
- 8. Which statement best describes the treatment plan in relation to the diagnosis?**
- A. It should be identical across all patient types**
 - B. It should be customized to the diagnosis**
 - C. It should be based solely on imaging**
 - D. It should avoid goals**
- 9. Adjustment credit is awarded only for work performed in certain classes.**
- A. True**
 - B. False**
 - C. Not sure**
 - D. Sometimes**
- 10. During referral creation, what action captures the referral rationale?**
- A. Enter the reason for the referral in the designated field and press Enter**
 - B. Click ADD to select diagnoses**
 - C. Search for the patient's name**
 - D. Change Assigned to**

Answers

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

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Explanations

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1. _____ term goals are where you expect to be at the end of the care plan, with that end date stated.

A. Long

B. Short

C. Medium

D. Immediate

Long-term goals are the outcomes you expect to reach by the end of the care plan, with a specific end date. They set the final target for the patient's progress, giving a clear time frame for when the plan should be completed. Short-term goals are the step-by-step milestones built to move toward that end state, checked regularly along the way. Immediate goals address current, pressing issues, while medium-term goals are typically intermediate milestones rather than the final endpoint. That end-dated target aligns with the long-term goal.

2. What is the primary focus of this week's lecture in the context of EHR? (week 3)

A. learning about patient billing codes

B. navigating the patient portal

C. learning about subjective and entering it into the EHR

D. data conversion from paper records

Week 3 centers on recording patient-reported information in the EHR—the subjective data. This is what the patient says about their symptoms, history, and concerns, captured accurately into the chart so clinicians can base assessments and plans on the patient's own words. That's why the option describing learning about subjective information and entering it into the EHR is the best fit. The other activities—handling billing codes, navigating the patient portal, or converting paper records to digital—are important parts of EHR use at other times, but they don't target the core task of documenting the patient's own reported information in the chart. For example, when a patient describes a headache and dizziness, this is entered as subjective data to reflect their experience, informing subsequent evaluation.

3. Which SOAP section describes the plan for future care?

A. Subjective

B. Objective

C. Assessment

D. Plan

In a SOAP note, the Plan section is where you lay out the plan for future care. This is the part that specifies what will be done next to manage the patient's condition, including treatments or medications, orders for tests or imaging, referrals to other providers, follow-up appointments, and patient education or instructions. The plan guides what happens after the visit, laying out concrete steps, timelines, and goals. The other sections capture different pieces of information: the Subjective section records what the patient reports (symptoms, feelings, and concerns); the Objective section contains measurable findings and observations from the exam or tests; the Assessment section provides the clinician's diagnosis or differential diagnosis and the reasoning behind it.

4. Why is it important to document both the listing and the technique used in the adjustments?

A. To provide clarity on what was done and guide others who may cover or read the note

B. To ensure the patient understands the procedure

C. To fulfill random auditing requirements

D. To increase the number of characters in the note

When documenting adjustments, capturing both the listing and the technique provides a precise and actionable record of exactly what was done. The listing identifies the specific spinal segment and the direction or orientation of the adjustment, while the technique describes how the adjustment was delivered—what method, hand placement, force, and maneuvers were used. Together, they create a clear, reproducible note that any clinician reading it can understand and replicate if needed, ensuring continuity of care across visits, staff handoffs, and when the chart is reviewed later. This level of detail also supports proper coding and documentation for billing, quality checks, and legal accountability by leaving little room for interpretation about what procedure was performed. While helping a patient understand their care is important, the primary purpose here is precise clinical communication and continuity, not patient education or meeting arbitrary audit or length requirements.

5. How can you ensure you are working on the correct progress note in the EHR?

A. verify the clinician's initials

B. check the date and ensure it matches the date of service

C. confirm the patient's address

D. review the last login time

The crucial idea here is to tie your documentation to the exact visit. In the EHR, a patient can have many progress notes, sometimes for different encounters or same-day visits. Verifying the date of service on the note ensures it matches the actual appointment you're documenting, so the note corresponds to the correct encounter and supports accurate billing and the patient's medical record. While clinician initials can tell you who wrote the note, they don't confirm that you're looking at the right encounter if multiple notes exist. The patient's address and the last login time don't indicate which visit or note you should be editing. If there's any doubt, check the encounter details to confirm the date and type of visit.

6. What is the primary purpose of the course taught by Dr. Jordahl?

- A. To introduce students to electronic health records and provide the required patient documentation components**
- B. To train clinicians in surgical procedures**
- C. To teach billing and coding for reimbursement**
- D. To study healthcare policy**

Understanding how digital patient records are built and what must be included in a care encounter is the key idea here. The course taught by Dr. Jordahl focuses on introducing students to electronic health records and the essential pieces that make up patient documentation. It trains you to navigate the EHR, enter accurate information, and ensure that all required components of the patient record are captured from demographics and medical history to medications, allergies, problem lists, progress notes, and orders/results. This foundation is crucial for safe, coordinated care, clear communication among clinicians, legal compliance, and reliable data for treatment decisions. Other topics like performing surgical procedures, learning billing and coding for reimbursement, or studying healthcare policy are important in their own right, but they fall outside the primary aim of this course, which is to build proficiency with EHR use and the standard documentation elements that constitute a complete patient record.

7. Which section of the SOAP note is used to record the clinician's direct observations during examination?

- A. Objective**
- B. Plan**
- C. Assessment**
- D. Subjective**

Direct observations from the examination belong in the section that captures what the clinician sees, measures, and tests. This is the Objective part of the SOAP note. It includes physical exam findings, vital signs, and results from tests or imaging—things observed or quantified by the clinician, such as “blood pressure 128/82,” “lung exam clear,” or “abdominal tenderness to palpation.” In contrast, what the patient reports about their symptoms and history goes in the Subjective section, the clinician’s impression or diagnosis goes in the Assessment, and the planned management or next steps go in the Plan. So the best choice is the section dedicated to the clinician’s direct examination findings.

8. Which statement best describes the treatment plan in relation to the diagnosis?

- A. It should be identical across all patient types**
- B. It should be customized to the diagnosis**
- C. It should be based solely on imaging**
- D. It should avoid goals**

Customizing the treatment plan to the specific diagnosis and patient context is essential. Different patients with the same diagnosis can have varying symptoms, severities, comorbidities, and personal goals, so a one-size-fits-all plan won't address those differences or optimize outcomes. Imaging helps confirm the diagnosis, but treatment decisions must consider the full clinical picture, including functional impact and safety. A good plan also includes clear goals and milestones to guide progress and adjustments. That's why tailoring the plan to the diagnosis is the best approach.

9. Adjustment credit is awarded only for work performed in certain classes.

- A. True**
- B. False**
- C. Not sure**
- D. Sometimes**

Adjustment credit is awarded only for work performed in certain classes because program policies designate specific classes as eligible for credit adjustments. This ensures that any extra or makeup work directly aligns with the learning objectives and assessment criteria of those approved classes. When work is completed within those targeted classes, it can be reviewed and credited according to the established rubric; outside of them, the credit would not be recognized because it wouldn't reflect the required content or standards. Therefore, the statement is true: eligibility is restricted to designated classes, not universal across all courses.

10. During referral creation, what action captures the referral rationale?

- A. Enter the reason for the referral in the designated field and press Enter**
- B. Click ADD to select diagnoses**
- C. Search for the patient's name**
- D. Change Assigned to**

The action that captures the referral rationale is entering the reason for the referral in the designated field and pressing Enter. This field is specifically designed to store the justification for the referral, so typing the rationale and confirming with Enter saves that information to the referral record, ensuring the receiving clinician understands why the referral was made. The other actions affect different parts of the workflow or data: adding diagnoses handles the patient's problem list, searching for the patient just finds the record, and changing who the referral is assigned to changes ownership or responsibility, not the rationale itself.

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://introductiontoehrpalmer.examzify.com>

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

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