

Medbridge Orthopedic Clinical Specialist (OCS) Test 1 Practice (Sample)

Study Guide



Everything you need from our exam experts!

Copyright © 2026 by Examzify - A Kaluba Technologies Inc. product.

ALL RIGHTS RESERVED.

No part of this book may be reproduced or transferred in any form or by any means, graphic, electronic, or mechanical, including photocopying, recording, web distribution, taping, or by any information storage retrieval system, without the written permission of the author.

Notice: Examzify makes every reasonable effort to obtain accurate, complete, and timely information about this product from reliable sources.

SAMPLE

Table of Contents

| | |
|------------------------------------|-----------|
| Copyright | 1 |
| Table of Contents | 2 |
| Introduction | 3 |
| How to Use This Guide | 4 |
| Questions | 5 |
| Answers | 9 |
| Explanations | 11 |
| Next Steps | 17 |

SAMPLE

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

SAMPLE

- 1. Which symptom is most characteristic of arterial thoracic outlet syndrome?**
 - A. Coldness of the hand**
 - B. Numbness of the fingers**
 - C. Weakness of intrinsic hand muscles**
 - D. Swelling**

- 2. In mechanical traction for low back pain, the patient is initially placed in which position to promote centralization of symptoms?**
 - A. Supine**
 - B. Prone**
 - C. Side-lying**
 - D. Seated**

- 3. According to Park et al., which combination of tests yields the best post-test probability for full-thickness rotator cuff tear?**
 - A. Painful arc sign, drop-arm sign, and infraspinatus muscle test**
 - B. Empty can test, external rotation lag sign, and Hornblower sign**
 - C. Painful arc sign, Hawkins-Kennedy test, and supraspinatus isolation test**
 - D. Drop-arm sign, abdominal crunch test, and biceps provocation test**

- 4. In the cervical myelopathy CPR, the age criterion is greater than which age?**
 - A. >40 years old**
 - B. >45 years old**
 - C. >50 years old**
 - D. >55 years old**

- 5. A physical therapist treats a patient with rheumatoid arthritis who develops a swan-neck deformity, with onset six months prior and increasing hand pain and restricted mobility over the last six weeks. Which intervention is most effective given the deformity progression?**
- A. Joint mobilization**
 - B. Strengthening**
 - C. Surgical intervention**
 - D. Stretching**
- 6. In adhesive capsulitis, stretching should be performed within tissue irritability limits because over-stretching can worsen outcomes.**
- A. Stretching at least two times per day will maximize ROM gains.**
 - B. Stretching beyond limits of a patient's pain can lead to poor outcomes.**
 - C. Stretching for sixty seconds with two repetitions per stretch increases pain.**
 - D. Stretching should be avoided in high irritability patients only.**
- 7. Which finding is part of the cervical spine myelopathy cluster described by Cook et al.?**
- A. Ataxia**
 - B. Numbness in fingertips**
 - C. Decreased reflexes**
 - D. Nocturnal neck pain**
- 8. Which mobilization has NOT been shown to improve heel pain symptoms in plantar fasciitis?**
- A. Cuboid thrust manipulation**
 - B. Proximal tibiofibular joint thrust manipulation**
 - C. Midtarsal pronation/supination nonthrust manipulation**
 - D. Distal tibiofibular joint posterior nonthrust manipulation**

- 9. Which statement accurately describes the prognosis of neurotmesis?**
- A. Excellent prognosis with therapy**
 - B. Poor prognosis due to complete nerve division**
 - C. Good prognosis with early surgical repair**
 - D. Prognosis depends on patient age**
- 10. Which muscle group can produce an anterior tibial shear on the knee but is not a primary stabilizer in PCL deficiency?**
- A. Biceps femoris**
 - B. Popliteus**
 - C. Quadriceps femoris**
 - D. Semimembranosus**

Answers

SAMPLE

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

SAMPLE

Explanations

SAMPLE

1. Which symptom is most characteristic of arterial thoracic outlet syndrome?

- A. Coldness of the hand**
- B. Numbness of the fingers**
- C. Weakness of intrinsic hand muscles**
- D. Swelling**

Arterial thoracic outlet syndrome causes reduced blood flow to the hand because the subclavian artery is compressed as it travels under the outlet structures. The hallmark consequence is ischemia in the distal hand, so the most characteristic symptom is coldness of the hand (often with pale color and diminished pulses). Numbness of the fingers can occur if nerves are involved, but that pattern is more typical of neurogenic TOS, where nerve compression produces sensory changes and sometimes weakness. Weak intrinsic hand muscle weakness points to nerve involvement or chronic ischemia affecting motor fibers, not the primary vascular insufficiency. Swelling suggests venous congestion, as seen in venous TOS, rather than arterial insufficiency. So coldness of the hand best reflects the arterial blood flow problem.

2. In mechanical traction for low back pain, the patient is initially placed in which position to promote centralization of symptoms?

- A. Supine**
- B. Prone**
- C. Side-lying**
- D. Seated**

Centralization of symptoms with traction relies on positioning that helps unload the nerve roots and move the irritant material away from the nerve pathways. Placing the patient in a prone position puts the lumbar spine in extension, which, when traction is applied along the spine, tends to decompress the posterior aspect of the spinal canal and open the central canal space. This setup supports pulling apart the vertebrae and can help retract disc material away from the nerve roots, making pain locate more toward the spine rather than radiating down the leg. Starting in this prone, extended position thus offers the best chance for centralization to occur. Supine (more flexion), side-lying, or seated positions are used in other contexts or for patient comfort, but they're not as effective first-line for promoting centralization with lumbar traction.

3. According to Park et al., which combination of tests yields the best post-test probability for full-thickness rotator cuff tear?

- A. Painful arc sign, drop-arm sign, and infraspinatus muscle test**
- B. Empty can test, external rotation lag sign, and Hornblower sign**
- C. Painful arc sign, Hawkins-Kennedy test, and supraspinatus isolation test**
- D. Drop-arm sign, abdominal crunch test, and biceps provocation test**

Combining signs that reflect a large rotator cuff tear increases the likelihood of confirming the tear after testing. The painful arc sign points to subacromial pain during mid-range elevation, which is common with rotator cuff involvement. The drop-arm sign shows an inability to control the arm during lowering after abduction, a classic indicator of a full-thickness supraspinatus tear and related cuff pathology. The infraspinatus muscle test assesses external rotation strength; weakness here suggests infraspinatus involvement, reinforcing the suspicion of a significant tear when paired with the other signs. Taken together, these three findings provide a stronger post-test probability for a full-thickness rotator cuff tear than any single test alone, because they cover both tear presence and the functional impact on the cuff. Other test sets may include signs that focus more on impingement or isolating a single muscle rather than indicating a full-thickness tear, or they combine with tests that assess unrelated structures (like the biceps or abdominal maneuvers). While those can be informative for broader shoulder pathology, they don't yield as high a post-test probability for a full-thickness tear when used together.

4. In the cervical myelopathy CPR, the age criterion is greater than which age?

- A. >40 years old**
- B. >45 years old**
- C. >50 years old**
- D. >55 years old**

The main idea here is how age factors into the cervical myelopathy clinical prediction rule. In this rule, being older increases the likelihood that a patient with neck symptoms has actual cervical myelopathy, because degenerative changes in the cervical spine—and their potential to compress the spinal cord—become more common with advancing age. When researchers developed the CPR, they found that an age cut-off of older than 45 years helped distinguish those with myelopathy from those without, especially when combined with other clinical findings. This threshold was chosen because it offered a useful balance of sensitivity and specificity in predicting cervical myelopathy, helping clinicians decide who should undergo further testing such as MRI. The other age options either capture too broad or too narrow a risk window given the data used to derive the rule, so the threshold of greater than 45 years is the most appropriate reference point within this CPR.

5. A physical therapist treats a patient with rheumatoid arthritis who develops a swan-neck deformity, with onset six months prior and increasing hand pain and restricted mobility over the last six weeks. Which intervention is most effective given the deformity progression?

- A. Joint mobilization**
- B. Strengthening**
- C. Surgical intervention**
- D. Stretching**

When rheumatoid arthritis produces a swan-neck deformity, the problem is a fixed imbalance of the finger's extensor mechanism and joint structures that often cannot be fully corrected with soft-tissue techniques alone. The PIP joint tends to hyperextend because the volar plate and surrounding structures become attenuated or damaged, while the cascade of joint changes limits flexion at the PIP and increases DIP motion restrictions. As the deformity progresses and the patient reports more pain and greater loss of function, simply mobilizing, stretching, or strengthening the involved fingers is less likely to restore meaningful function. The deformity represents structural changes that are best addressed by surgical correction to restore joint alignment and balance the extensor mechanism, thereby improving pain, motion, and grasp. In this scenario, surgical intervention offers the most effective path to functional improvement because it directly corrects the fixed deformity and reallocates tendon tension to restore use of the hand. Conservative approaches may help with symptoms, but they don't reliably reverse a progressing, fixed swan-neck deformity.

6. In adhesive capsulitis, stretching should be performed within tissue irritability limits because over-stretching can worsen outcomes.

- A. Stretching at least two times per day will maximize ROM gains.**
- B. Stretching beyond limits of a patient's pain can lead to poor outcomes.**
- C. Stretching for sixty seconds with two repetitions per stretch increases pain.**
- D. Stretching should be avoided in high irritability patients only.**

In adhesive capsulitis, the goal of stretching is to work tissues at a safe, tolerable level rather than pushing through pain. The joint capsule and surrounding structures are inflamed and fibrotic, so they have a limited tolerance for stretch. Going beyond the patient's pain limits can provoke increased pain, swelling, and protective muscle guarding, which can worsen inflammation, delay recovery, and even reduce ROM gains. By keeping stretches within tissue irritability limits, you promote gradual, safe remodeling of the capsule while avoiding temporary spikes in symptoms. If someone has higher irritability, you still stretch, but at gentler intensities, shorter holds, and closer symptom monitoring; as irritability lessens, progression can be made.

7. Which finding is part of the cervical spine myelopathy cluster described by Cook et al.?

- A. Ataxia**
- B. Numbness in fingertips**
- C. Decreased reflexes**
- D. Nocturnal neck pain**

Cervical myelopathy involves the spinal cord and produces upper motor neuron-type signs that affect gait and coordination. In the Cook et al. cluster, gait disturbance or ataxia reflects disruption of proprioception and corticospinal pathways from cord compression, making ataxia the finding that best fits a cord-based process. Numbness in the fingertips can occur with peripheral nerve or dermatomal issues rather than a cord syndrome, and decreased reflexes are more typical of lower motor neuron or radicular problems (or early spinal shock) rather than the classic UMN pattern seen with myelopathy. Nocturnal neck pain is non-specific and not a defining feature of the cord-based cluster.

8. Which mobilization has NOT been shown to improve heel pain symptoms in plantar fasciitis?

- A. Cuboid thrust manipulation**
- B. Proximal tibiofibular joint thrust manipulation**
- C. Midtarsal pronation/supination nonthrust manipulation**
- D. Distal tibiofibular joint posterior nonthrust manipulation**

Manual therapy for plantar fasciitis aims to modify foot and ankle mechanics to reduce strain on the plantar fascia. Not all mobilizations have proven benefits, and the evidence differs by the joint being treated. Themidtarsal joint mobilization focused on pronation and supination, done without thrust, has not consistently shown relief of heel pain in plantar fasciitis. In other words, nonthrust mobilization of themidtarsal joints does not appear to reliably reduce symptoms, even though it may improve midfoot mobility in other conditions. By contrast, mobilizations at nearby joints can influence overall foot mechanics and loading patterns in ways that the plantar fascia responds to more favorably. Techniques like cuboid thrust manipulation and thrust-like or posterior, nonthrust mobilizations at distal and proximal tibiofibular joints have been associated with symptom improvements in this condition, likely because they help restore more optimal alignment and load distribution across the hindfoot and lower leg. So, the mobilization that has not been shown to improve heel pain symptoms is themidtarsal pronation/supination nonthrust manipulation.

9. Which statement accurately describes the prognosis of neurotmesis?

- A. Excellent prognosis with therapy**
- B. Poor prognosis due to complete nerve division**
- C. Good prognosis with early surgical repair**
- D. Prognosis depends on patient age**

Neurotmesis is the most severe peripheral nerve injury, involving a complete transection of the nerve and disruption of its surrounding connective tissue. Because the axons are fully severed and the guiding endoneurial pathways are lost, spontaneous reinnervation across the gap does not occur. Without surgical repair to realign and reconnect the nerve ends, recovery is unlikely. Even when surgical repair is performed, outcomes are variable and often limited, since regenerating axons must grow long distances and reinnervate muscles that may have atrophied or reorganized, and misdirection of fibers can limit functional return. Early repair can improve the chance of recovery compared with delayed intervention, but it does not guarantee a good outcome. Age and other factors can influence regeneration, yet the defining issue remains the complete division of the nerve.

10. Which muscle group can produce an anterior tibial shear on the knee but is not a primary stabilizer in PCL deficiency?

- A. Biceps femoris**
- B. Popliteus**
- C. Quadriceps femoris**
- D. Semimembranosus**

The key idea is that anterior tibial shear is produced by quadriceps contraction. When the quadriceps fire, they pull the tibia forward relative to the femur, especially with the knee flexed, creating forward or anterior shear of the tibia on the femur. In PCL deficiency, the main job of the PCL is to prevent posterior translation of the tibia, so losing it makes the tibia more prone to move backward under load. But the quadriceps are not a primary stabilizer for this posterior restraint; they are knee extensors whose action can increase anterior translation rather than provide posterior stabilization. The other muscles listed tend to pull the tibia posteriorly or act mainly to unlock or control rotation, not to produce anterior tibial shear. So the quadriceps are the group capable of producing anterior tibial shear while not serving as the primary stabilizer in PCL deficiency.

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://medbridgeocs1.examzify.com>

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

SAMPLE