NPTE Scorebuilders OA Exam 1 Practice (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

1. **Stage II pressure ulcers are described as what type of skin loss?**

   A. Partial-thickness skin loss involving epidermis or dermis

   B. Full-thickness skin loss involving muscle

   C. Full-thickness skin loss exposing bone

   D. Slough with dead tissue only

2. **The deltoid muscle, a primary shoulder abductor, is innervated by which nerve?**

   A. Musculocutaneous nerve

   B. Radial nerve

   C. Axillary nerve

   D. Median nerve

3. **A patient admitted with adhesive capsulitis presents with an insidious onset of pain and stiffness over the past several months. Which patient profile is MOST likely associated with this diagnosis?**

   A. 58-year-old female with multiple sclerosis

   B. 45-year-old male with peripheral neuropathy

   C. 52-year-old male with recurrent rotator cuff tendinopathy

   D. 48-year-old female with diabetes

4. **Which anatomical variation in females contributes to a higher incidence of Osgood-Schlatter syndrome compared to males?**

   A. Decreased pronation

   B. Decreased Q angle

   C. Increased femoral anteversion

   D. Genu varus

5. **When testing two-point discrimination, which body area would most likely yield the SMALLEST value?**

   A. Cheek

   B. Lateral to the umbilicus

   C. Medial forearm

   D. Medial leg

6. A patient with arteriosclerosis obliterans begins a treadmill walking program and develops leg pain after two minutes. What is the most appropriate action?

A. Decrease the treadmill speed by one-half mile per hour and instruct the patient to continue walking

B. Walk through the pain unless it becomes unbearable

C. Rest and resume walking when the pain subsides

D. Discontinue walking and select an alternate exercise

7. A patient with a hemoglobin of 7.8 g/dL is planning ambulation after knee arthroplasty. What is the most appropriate activity level?

A. No physical activity

B. Slow ambulation

C. Low-level resistive exercises

D. There is no restriction to physical activity

8. In a patient with left spatial neglect, which strategy is most effective to promote attention to the left side during treatment sessions?

A. Inability to attend to stimuli on the left

B. Language difficulty

C. Decreased sensation in the left arm

D. Facial droop on the left

9. Which medication used to reduce spasticity in multiple sclerosis commonly causes generalized weakness as a side effect?

A. Levodopa

B. Baclofen

C. Gabapentin

D. Diazepam

10. Postoperative PT notes swollen, warm calf and pain with dorsiflexion after open reduction internal fixation. The MOST likely explanation is which condition?

A. Compartment syndrome

B. Deep vein thrombosis

C. Infection

D. Peroneal nerve palsy

Answers

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

Explanations

1. Stage II pressure ulcers are described as what type of skin loss?

A. Partial-thickness skin loss involving epidermis or dermis

B. Full-thickness skin loss involving muscle

C. Full-thickness skin loss exposing bone

D. Slough with dead tissue only

Stage II pressure ulcers involve partial-thickness skin loss, affecting the epidermis and possibly the dermis. This produces a shallow, open ulcer or a blister that is pink/red and moist. Because only the superficial layers are damaged, there is no exposure of muscle, bone, or deeper tissues—those would be full-thickness losses. If necrotic tissue or slough covers the wound, the injury isn't Stage II and is typically described as unstageable or, depending on tissue depth, a deeper category. So the correct description is partial-thickness skin loss involving the epidermis or dermis.

2. The deltoid muscle, a primary shoulder abductor, is innervated by which nerve?

A. Musculocutaneous nerve

B. Radial nerve

C. Axillary nerve

D. Median nerve

The deltoid muscle is innervated by the axillary nerve. This nerve comes from the posterior cord of the brachial plexus (C5–C6) and travels through the quadrangular space with the posterior circumflex humeral artery to reach the deltoid. The deltoid is the main mover for shoulder abduction after the first 15 degrees, with the initial 0–15 degrees of abduction primarily performed by the supraspinatus. Therefore, when the axillary nerve is intact, the deltoid can abduct the arm from about 15 to 90 degrees and beyond with trapezius and serratus anterior assistance. If the axillary nerve is compromised, abduction is weak beyond the initial portion, reflecting its role. The other nerves supply different muscle groups: musculocutaneous to the anterior arm, radial to posterior arm and forearm extensors, and median to many forearm flexors and hand muscles.

3. A patient admitted with adhesive capsulitis presents with an insidious onset of pain and stiffness over the past several months. Which patient profile is MOST likely associated with this diagnosis?

A. 58-year-old female with multiple sclerosis

B. 45-year-old male with peripheral neuropathy

C. 52-year-old male with recurrent rotator cuff tendinopathy

D. 48-year-old female with diabetes

Adhesive capsulitis, or frozen shoulder, is strongly linked to diabetes because metabolic changes from hyperglycemia promote fibrosis and thickening of the shoulder joint capsule. Nonenzymatic glycation of collagen leads to cross-linking and stiffening of the capsular tissue, with inflammatory mediators driving synovial proliferation and adhesions. Clinically, it presents as a gradual, insidious onset of pain and progressive loss of range of motion, often with a capsular pattern where external rotation is most limited, followed by abduction and internal rotation. The profile with diabetes fits this pattern and risk, making it the most likely association. The other profiles don't align as closely with adhesive capsulitis. Multiple sclerosis is a central nervous system condition rather than a known risk factor for this shoulder pathology; peripheral neuropathy can cause shoulder symptoms but not the classic capsular restriction pattern; recurrent rotator cuff tendinopathy causes more focal pain and weakness with different movement limitations rather than the diffuse, progressive ROM loss characteristic of a stiff, fibrotic capsule.

4. Which anatomical variation in females contributes to a higher incidence of Osgood-Schlatter syndrome compared to males?

A. Decreased pronation

B. Decreased Q angle

C. Increased femoral anteversion

D. Genu varus

Osgood-Schlatter syndrome occurs from repetitive traction of the patellar tendon on the tibial tubercle during growth spurts. Anything that increases the tensile forces at that apophysis during activities like jumping or sprinting raises the risk. Increased femoral anteversion causes the femur to sit more internally rotated, which alters knee alignment and places the knee under greater valgus/rotational stress during dynamic activities. This shifts the mechanics so the quadriceps–patellar tendon complex pulls more forcefully on the tibial tubercle, heightening traction at the insertion point. That augmented traction during growth years explains why this anatomical variation is linked with a higher incidence of Osgood-Schlatter in females. The other options don't produce the same increase in tibial tubercle traction: changes like decreased pronation, decreased Q angle, or genu varus tend to reduce or alter knee mechanics in ways that don't specifically amplify the traction at the tibial tubercle during quadriceps loading.

5. When testing two-point discrimination, which body area would most likely yield the SMALLEST value?

A. Cheek

B. Lateral to the umbilicus

C. Medial forearm

D. Medial leg

Two-point discrimination reflects tactile acuity determined by receptor density and receptive-field size. Regions with many small, densely packed mechanoreceptors and a large cortical representation—like the face—can resolve two close points at a very small separation. The cheek has these characteristics, so it yields the smallest threshold. In contrast, areas such as near the umbilicus, along the medial forearm, or the medial leg have larger receptive fields and fewer receptors per area, producing larger thresholds and less precise discrimination. Therefore, the cheek would give the smallest value.

6. A patient with arteriosclerosis obliterans begins a treadmill walking program and develops leg pain after two minutes. What is the most appropriate action?

A. Decrease the treadmill speed by one-half mile per hour and instruct the patient to continue walking

B. Walk through the pain unless it becomes unbearable

C. Rest and resume walking when the pain subsides

D. Discontinue walking and select an alternate exercise

In peripheral arterial disease, leg pain during walking is intermittent claudication caused by insufficient blood flow to the working muscles. The best approach during a supervised walking program is to stop walking when claudication begins and rest until the pain subsides, then resume walking at a comfortable pace. This rest–recovery pattern allows reperfusion, prevents worsening ischemia, and gradually builds endurance as the patient reinitiates activity. Pushing through the pain or forcing a longer walk without relief can worsen symptoms and fatigue. Decreasing speed or choosing a different exercise isn't necessary if pain subsides with rest and the patient can resume walking, which is the standard, progressive method for improving walking tolerance in PAD.

7. A patient with a hemoglobin of 7.8 g/dL is planning ambulation after knee arthroplasty. What is the most appropriate activity level?

A. No physical activity

B. Slow ambulation

C. Low-level resistive exercises

D. There is no restriction to physical activity

The key concept is that low hemoglobin limits the body's ability to deliver oxygen to working muscles during activity. With a hemoglobin around 7.8 g/dL, oxygen delivery is markedly reduced, so even light exertion can provoke fatigue, tachycardia, dizziness, or chest symptoms in a postoperative patient. In the knee replacement rehab setting, safety takes priority when anemia is that pronounced: ambulation or any physical activity that increases oxygen demand could provoke hemodynamic stress. Therefore the most appropriate approach at this level is to avoid physical activity and defer ambulation and more exertional therapy until the hemoglobin is corrected or the patient is cleared by the physician. Monitor for symptoms and reassess as hemoglobin improves or treatment is instituted.

8. In a patient with left spatial neglect, which strategy is most effective to promote attention to the left side during treatment sessions?

A. Inability to attend to stimuli on the left

B. Language difficulty

C. Decreased sensation in the left arm

D. Facial droop on the left

Left spatial neglect reflects a failure to attend to stimuli on the left side, usually after a right-hemisphere brain injury. The most effective way to promote attention to the left during treatment is to actively cue and prompt the patient to engage with leftward stimuli, helping reorient attention toward the neglected space. This can be done by presenting tasks and meaningful items on the left, giving clear verbal prompts like “look to the left,” and using tactile or visual cues to draw the patient’s gaze and head orientation toward the left. Over time, cues can be gradually reduced as the patient begins to explore the left space more independently. Language difficulty, decreased sensation on the left, and facial droop are separate deficits that don’t directly address the attentional bias in neglect, so they don’t provide the same targeted benefit for promoting leftward attention during therapy.

9. Which medication used to reduce spasticity in multiple sclerosis commonly causes generalized weakness as a side effect?

A. Levodopa

B. Baclofen

C. Gabapentin

D. Diazepam

Baclofen reduces spasticity in MS by activating GABA-B receptors in the spinal cord, which dampens reflex excitability and lowers muscle tone. A well-known, dose-related side effect is generalized weakness or fatigue, stemming from the same CNS depressant action that decreases motor neuron output and overall muscle strength. While other drugs in the list have different primary uses or side effect profiles, the link between baclofen and generalized weakness is the most characteristic in the context of MS spasticity management.

10. Postoperative PT notes swollen, warm calf and pain with dorsiflexion after open reduction internal fixation. The MOST likely explanation is which condition?

A. Compartment syndrome

B. Deep vein thrombosis

C. Infection

D. Peroneal nerve palsy

Painful, swollen calf that is warm after lower-limb surgery points to a deep vein thrombosis. The combination fits Virchow's triad—venous stasis from postoperative immobility, endothelial injury from surgery, and potential hypercoagulability—making a clot in the deep veins likely. Pain with dorsiflexion (often described as a Homan sign) can accompany DVT, though it isn't perfectly specific; in the postoperative setting, unilateral swelling and warmth are red flags for a clot rather than other conditions. Compartment syndrome would present with disproportionately severe pain, tense swelling, and pain on passive stretch with potential neurovascular compromise, which is more acute and exam-specific. Infection would usually show wound-related signs or systemic symptoms like fever. Peroneal nerve palsy would cause motor deficit such as foot drop, not primarily calf swelling and warmth. Thus, the most probable explanation is deep vein thrombosis, which requires urgent medical evaluation and imaging to confirm and guide treatment.

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://nptescorebuildersoa1.examzify.com

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