

OMM PRINCIPLES AND PRACTICE OF OSTEOPATHIC MEDICINE II (PPOMII) PRACTICAL 1 PRACTICE TEST (SAMPLE)

STUDY GUIDE



**SAMPLE STUDY GUIDE
WITH LIMITED QUESTIONS**

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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.

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. Bilateral Temporal Contact (Becker Variation) is a variation of which technique?**
 - A. OA Decompression
 - B. Becker Hold
 - C. Flexion Hand Placements
 - D. Rotation Hand Placements
- 2. Which cranial OMM technique has an alternative hand placement for the frontal lift?**
 - A. Frontal Lift
 - B. Frontal Lift Alternative Hand placement
 - C. Parietal Lift
 - D. Nasion Spread: Naso-frontal suture release
- 3. Which HVLA technique is used for the posterior tibia SD HVLA?**
 - A. Posterior tibia SD HVLA
 - B. Anterior tibia SD HVLA
 - C. MET Hip flexion SD
 - D. MET Hip extension SD
- 4. Which technique applies a direct membranous tension in cranial OMM?**
 - A. Direct Balanced Membranous Tension
 - B. Indirect Balanced Membranous Tension
 - C. Inferior Vertical Strain Hand Placements
 - D. Frontal Lift
- 5. In HVLA for Posterior Rotated Innominate Dysfunction, which statement is true about the thrust?**
 - A. The thrust is downward through the iliac crest.
 - B. The thrust is directed posteriorly toward the sacrum.
 - C. The thrust is like punching yourself in anterosuperior direction.
 - D. The thrust is directed medially across the symphysis.

6. Which counterstrain designation corresponds to talocalcaneal eversion?

- A. Tibiotalar dorsiflexion SD MET
- B. Tibiotalar plantarflexion SD MET
- C. Talocalcaneal eversion SD MET
- D. Talocalcaneal inversion SD MET

7. MET adduction SD is applied to which joint?

- A. Acromioclavicular joint
- B. Sternoclavicular joint
- C. Glenohumeral joint
- D. Scapulothoracic articulation

8. Which bones form the subtalar joint?

- A. Talus and Navicular
- B. Calcaneus and Cuboid
- C. Tibia and Fibula
- D. Talus and Calcaneus

9. In Hip External Rotation SD MET, which action creates external rotation?

- A. Pt in supine, stand on side of SD
- B. Flex Hip and Knee to 90 Degrees
- C. Stabilize Bent Knee with One Hand, Other Hand Pulls Foot Laterally to Create External Rotation
- D. Pt Pushes Foot Laterally

10. OA Decompression is used to decompress which joint?

- A. Occipitoatlantal joint
- B. Sphenobasilar synchondrosis
- C. Atlantoaxial joint
- D. Cranial sutures

Answers

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

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Explanations

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1. Bilateral Temporal Contact (Becker Variation) is a variation of which technique?

- A. OA Decompression
- B. Becker Hold**
- C. Flexion Hand Placements
- D. Rotation Hand Placements

The Bilateral Temporal Contact variant is a refinement of a specific cranial hold known as the Becker Hold. In this variation, both temporal bones are contacted to create a balanced, bilateral influence on the cranial mechanism, which helps harmonize the cranial rhythmic impulse and address bilateral temporal/spheno-basilar tensions. It's not a different technique like OA decompression or a generic hand-placement approach; it's the Becker Hold adapted to use bilateral temporal contact. The other options describe different techniques or placements that don't embody this particular bilateral temporal refinement.

2. Which cranial OMM technique has an alternative hand placement for the frontal lift?

- A. Frontal Lift
- B. Frontal Lift Alternative Hand placement**
- C. Parietal Lift
- D. Nasion Spread: Naso-frontal suture release

The idea being tested is that there is a variant of the frontal lift in cranial osteopathy that uses an alternative hand placement. In cranial work, the frontal lift is used to influence the frontal bones and help balance the cranial rhythmic impulse, but practitioners may employ different hand configurations to optimize contact, vector, and comfort for the patient. The option that specifically names an "alternative hand placement" for the frontal lift directly reflects this variation, making it the most accurate choice for describing a frontal lift done with a different hand arrangement. The other techniques—parietal lift and nasion spread focusing on different regions and sutures—do not pertain to modifying hand placement for the frontal lift, so they don't answer the question.

3. Which HVLA technique is used for the posterior tibia SD HVLA?

- A. Posterior tibia SD HVLA**
- B. Anterior tibia SD HVLA
- C. MET Hip flexion SD
- D. MET Hip extension SD

For a posterior tibia somatic dysfunction, the tibia sits back relative to the femur and its forward (anterior) glide is limited. The HVLA correction is a quick, targeted thrust that moves the tibia anteriorly to restore proper alignment and motion at the knee and tibia-fibula relationship. The maneuver specifically designed for this pattern is the posterior tibia SD HVLA, which is applied to correct the posteriorly positioned tibia. Choosing an anterior tibia HVLA would be for a tibia that's stuck forward, not posteriorly. Muscle energy techniques at the hip are different approaches (non-HVLA) and address hip motion rather than directing a HVLA thrust on the tibia.

4. Which technique applies a direct membranous tension in cranial OMM?

- A. Direct Balanced Membranous Tension
- B. Indirect Balanced Membranous Tension
- C. Inferior Vertical Strain Hand Placements
- D. Frontal Lift

Direct membranous tension in cranial OMM involves applying a gentle, direct load to the cranial membranes to influence the primary respiratory mechanism. Balanced Membranous Tension uses both hands to apply equal, mild tension to the membranes so the system sits in a neutral, balanced state. This direct engagement with the membranes is what characterizes the technique as direct, as you are loading the membranous system itself rather than creating release by moving away from the restriction. The other options describe different approaches or targets—for example, indirect methods that release by allowing the tissues to move away from the restriction, or techniques that focus on specific bone placements rather than the membranous system as a whole.

5. In HVLA for Posterior Rotated Innominate Dysfunction, which statement is true about the thrust?

- A. The thrust is downward through the iliac crest.
- B. The thrust is directed posteriorly toward the sacrum.
- C. The thrust is like punching yourself in anterosuperior direction.
- D. The thrust is directed medially across the symphysis.

In a posterior rotated innominate, the ilium sits rotated backward relative to the sacrum. The correction is achieved by a rapid, targeted HVLA thrust that moves the ilium anteriorly and slightly upward. That anterosuperior direction is what reorients the innominate so the ilium rotates toward a more normal position relative to the sacrum. The "punching yourself in anterosuperior direction" image captures this vector: a quick, forward-and-up thrust to restore balance at the SI joint and pubic area without driving downward or straight back. Other thrust directions wouldn't address the rotation effectively: a downward thrust through the iliac crest isn't aimed at reversing the posterior rotation; a posteriorly directed thrust toward the sacrum reinforces the misalignment; and a medial thrust across the symphysis mainly affects the pubic bones rather than realigning the ilium itself.

6. Which counterstrain designation corresponds to talocalcaneal eversion?

- A. Tibiotalar dorsiflexion SD MET
- B. Tibiotalar plantarflexion SD MET
- C. Talocalcaneal eversion SD MET
- D. Talocalcaneal inversion SD MET

The key idea is how counterstrain designations are named: they specify the joint involved and the direction in which you place the body to create a position of ease. A talocalcaneal (subtalar) eversion designation means the tender point lies at the subtalar joint and is treated by placing the foot in eversion. The subtalar joint allows inversion and eversion of the foot. When a tender point is associated with talocalcaneal eversion, the treatment position is to position the foot so the subtalar joint is in eversion, releasing the tissue tension at that point. The other options point to different joints or directions (tibiotalar motions or inversion) and would target different tender points.

7. MET adduction SD is applied to which joint?

- A. Acromioclavicular joint
- B. Sternoclavicular joint**
- C. Glenohumeral joint
- D. Scapulothoracic articulation

In MET, you use the patient's own muscle contraction to move a dysfunctional joint toward the restrictive barrier, then releasing to reset. For a somatic dysfunction at the sternoclavicular joint where adduction (clavicular retraction toward the midline) is limited, you have the patient actively retract the medial clavicle against gentle resistance. The clinician supports the medial clavicle, the patient contracts the muscles that pull the clavicle medially (retracting the shoulder girdle), holds briefly, then relaxes and you ease off to allow the joint to reset toward a more neutral position. The sternoclavicular joint is where this adduction/retraction movement is primary, making it the correct target for MET adduction in this context; other joints listed have different primary movements and are treated with different MET directions.

8. Which bones form the subtalar joint?

- A. Talus and Navicular
- B. Calcaneus and Cuboid
- C. Tibia and Fibula
- D. Talus and Calcaneus**

The subtalar joint is formed by the articulation between the talus and the calcaneus. The talus rests on the superior surface of the calcaneus, and their inferior/superior articular facets come together to create this synovial plane joint. This arrangement allows small gliding movements that enable inversion and eversion of the foot, which are essential for adapting to uneven terrain during walking. The ankle joint proper involves the tibia, fibula, and talus, but the subtalar joint specifically concerns the talus and calcaneus. Other hindfoot joints, like the talonavicular and calcaneocuboid joints, are separate articulations.

9. In Hip External Rotation SD MET, which action creates external rotation?

- A. Pt in supine, stand on side of SD
- B. Flex Hip and Knee to 90 Degrees
- C. Stabilize Bent Knee with One Hand, Other Hand Pulls Foot Laterally to Create External Rotation**
- D. Pt Pushes Foot Laterally

In this MET for the hip, you want to produce external rotation at the hip joint, isolating the motion to the hip rather than the knee or pelvis. Stabilizing the bent knee with one hand fixes the distal segment, and using the other hand to pull the foot laterally drives the femur into external rotation. This setup ensures the rotation comes from the hip itself, providing the proper barrier for the muscle-energy sequence and a clear target for the patient to contract against. The alternative of having the patient push the foot laterally relies on the patient's own force without ensuring the hip is isolated, which can invite movement at the knee or pelvis and doesn't consistently create a clean external rotation at the hip.

10. OA Decompression is used to decompress which joint?

- A. Occipitoatlantal joint**
- B. Sphenobasilar synchondrosis**
- C. Atlantoaxial joint**
- D. Cranial sutures**

OA decompression targets the occipitoatlantal joint—the articulation between the occipital bone and the atlas (C1). In cranial osteopathy this joint is a primary site of motion and dural tension, so releasing restrictions here helps free the OA articulation, normalize cranial motion, and ease dural strain. The technique is performed with gentle contact at the occiput to allow the atlas and occipital condyles to separate slightly, restoring freer motion at the OA articulation. This specific approach is not aimed at the atlantoaxial joint (C1–C2), the midline sphenobasilar synchondrosis, or cranial sutures—the OA joint is the direct target for this decompression maneuver.

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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:

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

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