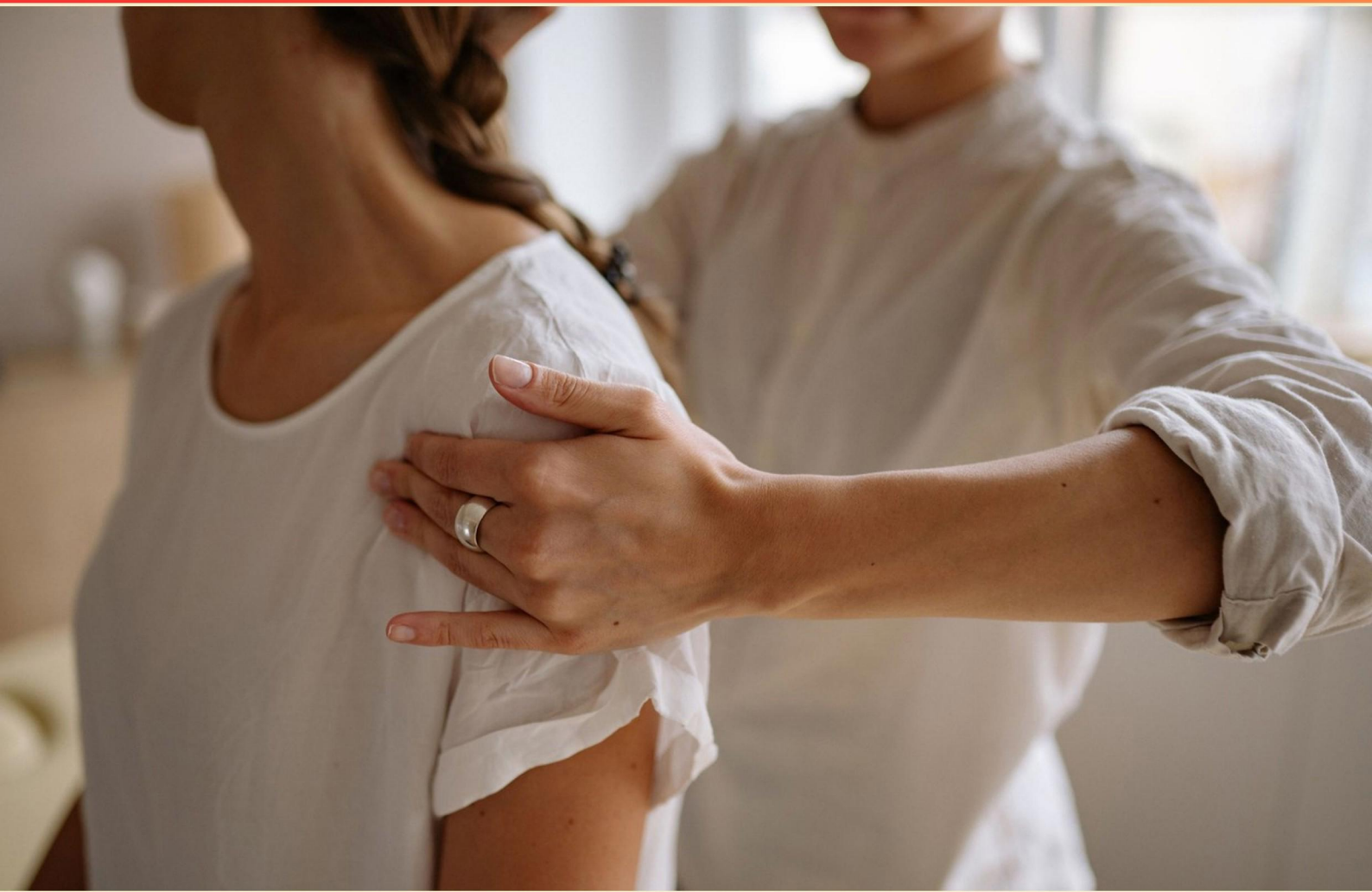


PERSON-FIRST LANGUAGE, COMMUNICATION, AND BIAS IN PHYSICAL THERAPY PRACTICE TEST (SAMPLE)

STUDY GUIDE



SAMPLE STUDY GUIDE WITH LIMITED QUESTIONS

VISIT US ONLINE FOR
THE FULL VERSION STUDY GUIDE

[https://
personfirstlangcommbiasinphytherapy.examzify.com](https://personfirstlangcommbiasinphytherapy.examzify.com)



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	8
Explanations	10
Next Steps	16

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. What is a common mistake in language about disability that PTs should avoid?**
 - A. Using dehumanizing terms like 'the disabled' or pity; emphasize personhood.
 - B. Using person-first language.
 - C. Describing functional limitations only.
 - D. Relying on medical labels.

- 2. In a multidisciplinary team meeting, how can you advocate for disability-inclusive language?**
 - A. Ignore terms
 - B. Model person-first language, explain preferred terms, and gently challenge biased statements; provide alternatives
 - C. Use medical jargon
 - D. Blame others

- 3. What does IPEC stand for?**
 - A. Interprofessional Education Collaborative
 - B. International Physical Exercise Council
 - C. Integrated Practice and Education Council
 - D. Institute for Professional Education and Collaboration

- 4. Why is consent ongoing in rehabilitation, and how is it documented?**
 - A. Consent is a one-time form
 - B. Consent is only verbal
 - C. Because treatment plans can change; obtain ongoing consent and document updates
 - D. Consent is not needed after initial

- 5. Which statement best supports fair discussion of treatment costs?**
 - A. Present options neutrally, consider barriers, and avoid assumptions about adherence.
 - B. Always push the most affordable option.
 - C. Avoid discussing costs entirely.
 - D. Rely solely on clinician preference.

- 6. Which statement is true about psychosocial prognostic factors used in yellow flags?**
- A. Depression
 - B. Pain intensity
 - C. Range of motion
 - D. BMI
- 7. What is a common consequence of bias in clinical reasoning?**
- A. Premature conclusions and missed diagnoses due to stereotypes shaping pattern recognition.
 - B. Increased diagnostic accuracy
 - C. A more efficient system
 - D. More patient engagement
- 8. If a patient uses identity-first language, what is the recommended approach for clinicians?**
- A. Persist with person-first language to maintain consistency.
 - B. Mirror the patient's language while continuing to use person-centered language.
 - C. Always correct them to use person-first language.
 - D. Use clinical terminology without patient input.
- 9. What is the proper approach to documenting patient preferences in the medical record?**
- A. Document preferences and decisions; include consent.
 - B. Document only if asked.
 - C. Leave preferences out of notes.
 - D. Document preferences separately from medical record.
- 10. Which statement best describes the role of nonverbal communication in clinical encounters?**
- A. It supports empathy and trust-building.
 - B. It replaces verbal explanations.
 - C. It is used only with family members.
 - D. It delays care.

Answers

SAMPLE

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

SAMPLE

Explanations

SAMPLE

1. What is a common mistake in language about disability that PTs should avoid?

- A. Using dehumanizing terms like 'the disabled' or pity; emphasize personhood.**
- B. Using person-first language.
- C. Describing functional limitations only.
- D. Relying on medical labels.

Language matters in how we perceive and engage with people who have disabilities; using dehumanizing terms is a common mistake PTs should avoid. Saying "the disabled" or expressing pity frames disability as the defining attribute and as a deficit, which can strip a person of individuality and dignity. This kind of language can create distance, reduce collaboration, and undermine shared decision-making in rehabilitation. In contrast, emphasizing personhood and using respectful, person-first language—such as "a person with a disability"—centers the person, honors their identity, and supports a collaborative, patient-centered approach. It signals respect for autonomy, reduces bias, and can improve trust, engagement, and outcomes. Other approaches—focusing only on functional limitations or relying solely on medical labels—risk narrowing the interaction, overlooking the person's goals and strengths, and reinforcing a clinician-centered view rather than a partnership.

2. In a multidisciplinary team meeting, how can you advocate for disability-inclusive language?

- A. Ignore terms
- B. Model person-first language, explain preferred terms, and gently challenge biased statements; provide alternatives**
- C. Use medical jargon
- D. Blame others

Fostering disability-inclusive language is about using and teaching language that centers the person, not the condition, in a team setting. In a multidisciplinary meeting, modeling person-first language, clarifying preferred terms, and gently challenging biased statements while offering alternatives creates a respectful, learning-focused environment. When you consistently say "a person with a disability" rather than labeling someone by the disability, you keep the person's humanity front and center and set a standard for others to follow. Explaining which terms are preferred helps teammates understand why certain words are more accurate or dignified, which makes it easier for them to adopt them. When biased or demeaning remarks arise, addressing them calmly and providing respectful alternatives—without shaming—keeps the conversation constructive and reduces the risk of stigma within the team and in patient care. This approach matters because language shapes how people are perceived and how decisions are made about care. It supports patient autonomy, builds trust, and promotes inclusive collaboration across disciplines. Ignoring terminology allows bias to persist; using medical jargon alone can distance the team from the patient's lived experience; blaming others shuts down dialogue and learning. Embracing inclusive language and gentle guidance keeps the focus on respectful communication and high-quality, person-centered care.

3. What does IPEC stand for?

- A. Interprofessional Education Collaborative
- B. International Physical Exercise Council
- C. Integrated Practice and Education Council
- D. Institute for Professional Education and Collaboration

Understanding what IPEC stands for helps you connect to how health professions train to work together. IPEC is Interprofessional Education Collaborative, a well-known group formed to advance interprofessional education and collaborative practice across health professions. This matters in physical therapy because IPEC frameworks and Core Competencies guide teamwork with other clinicians, ultimately supporting safer, more patient-centered care. The other options aren't the recognized name of this organization, so they don't fit with how IPEC is used in education and practice.

4. Why is consent ongoing in rehabilitation, and how is it documented?

- A. Consent is a one-time form
- B. Consent is only verbal
- C. Because treatment plans can change; obtain ongoing consent and document updates
- D. Consent is not needed after initial

Ongoing consent is about treating consent as a continuing, collaborative process rather than a single event. In rehabilitation, treatment plans often evolve as a patient progresses, encounters new information, or faces changing goals, risks, or tolerances. Because of that, it's essential to regularly check in with the patient, confirm they understand the current plan, and obtain their agreement before proceeding with any new or altered interventions. This ongoing dialogue protects the patient's autonomy and supports person-centered care, ensuring decisions reflect the patient's values, preferences, and current situation. Documentation matters because it creates a clear record that the patient was informed, understood, and consented to each change. It should capture what was discussed, any questions or concerns, the specific changes to the plan, who obtained the consent, and the date. This helps ensure accountability, supports continuity of care, and provides a legal and ethical record that the patient was engaged in decisions about their treatment. Verbal consent can occur, but it must be followed by timely documentation of what was discussed and agreed. The idea that consent is a one-time form or not needed after the initial visit is incorrect because it ignores how plans can shift and why re-affirmation and record-keeping are necessary.

5. Which statement best supports fair discussion of treatment costs?

- A. Present options neutrally, consider barriers, and avoid assumptions about adherence.**
- B. Always push the most affordable option.
- C. Avoid discussing costs entirely.
- D. Rely solely on clinician preference.

Fair discussion of treatment costs hinges on transparent, patient-centered communication about options, including their financial implications, while recognizing possible barriers and avoiding assumptions about whether a patient will adhere. Presenting options neutrally means describing each treatment path, how it works, and the typical costs or out-of-pocket impact without steering toward a particular choice. It also means being honest about trade-offs between effectiveness, convenience, and cost so the patient can weigh what matters most to them. Considering barriers involves asking about financial constraints, transportation, time off work, insurance coverage, copays, and access to services. This helps identify hurdles early and allows the plan to be tailored to what the patient can actually manage. Avoiding assumptions about adherence prevents shaping recommendations based on stereotypes or incomplete judgments about a patient's likelihood to follow through. Instead, discuss how costs might affect adherence and collaborate to find feasible, acceptable solutions or alternatives. Other approaches fall short because pushing the cheapest option can compromise effectiveness, avoiding cost discussions deprives the patient of essential information for informed choice, and relying solely on clinician preference ignores the patient's values, finances, and real-world constraints. This patient-centered approach supports equitable, effective care and shared decision-making.

6. Which statement is true about psychosocial prognostic factors used in yellow flags?

- A. Depression**
- B. Pain intensity
- C. Range of motion
- D. BMI

Psychosocial prognostic factors in yellow flags focus on mental health and social context and how they influence recovery from pain. Depression fits this category because it affects mood, motivation, coping strategies, and expectations about treatment and outcomes. When depressive symptoms are present, a person may engage less with rehabilitation, report higher perceived intensity of pain, and have slower progress toward returning to work, all of which can worsen prognosis. Pain intensity, while important, is a sensory symptom rooted in physical and neurobiological processes rather than a psychosocial context factor. Range of motion and BMI are physical measurements that describe impairments or body characteristics, not psychosocial risk factors. Therefore, depression is the best answer because it directly represents the psychosocial dimension that yellow flags are designed to identify and address. In practice, clinicians screen for depression to tailor management and support, recognizing how mental health can shape recovery.

7. What is a common consequence of bias in clinical reasoning?

- A. Premature conclusions and missed diagnoses due to stereotypes shaping pattern recognition.**
- B. Increased diagnostic accuracy
- C. A more efficient system
- D. More patient engagement

Bias in clinical reasoning can distort how information is gathered and interpreted. When stereotypes or preconceived notions about a patient shape pattern recognition, clinicians may prematurely lock onto a diagnosis that seems to fit the stereotype rather than what the data actually show. This leads to premature conclusions and missed diagnoses because important clues that don't align with the stereotype are overlooked. In practice, this means pattern recognition becomes biased toward an expected category, undermining diagnostic accuracy and potentially delaying appropriate testing or referrals. For example, a clinician who assumes a certain presentation is typical for a specific condition might overlook red flags or alternative explanations that don't fit that expectation, especially in a person-first approach where the individual is seen as a whole person with unique experiences. This is not a benefit to diagnostic accuracy, efficiency, or patient engagement. Bias tends to reduce accuracy, can introduce errors and delays, and may undermine trust and engagement if care feels stereotyped or dismissive.

8. If a patient uses identity-first language, what is the recommended approach for clinicians?

- A. Persist with person-first language to maintain consistency.
- B. Mirror the patient's language while continuing to use person-centered language.**
- C. Always correct them to use person-first language.
- D. Use clinical terminology without patient input.

Respecting how a person describes themselves is central to patient-centered care. When a patient uses identity-first language, such as "autistic person," the clinician should mirror that wording. This validates the patient's self-identification and helps build trust and engagement in the care plan. At the same time, keep the focus on the person—treat them as a whole individual with goals, values, and dignity beyond their condition—so language remains respectful and person-centered. Mirroring the patient's terminology supports autonomy and reduces power imbalances in the clinician–patient relationship. Pushing a different language, like always insisting on person-first terminology, can feel invalidating to someone who identifies with identity-first language. Conversely, using clinical jargon without patient input can create distance and imply that the patient's preferences aren't important. If unsure, ask how they'd like to be described and follow their lead.

9. What is the proper approach to documenting patient preferences in the medical record?

- A. Document preferences and decisions; include consent.**
- B. Document only if asked.
- C. Leave preferences out of notes.
- D. Document preferences separately from medical record.

Focusing on documenting patient preferences and consent in the medical record centers on aligning care with the person's goals and values. When you record what matters to the patient, the decisions they make about their treatment, and their consent to the proposed plan, you create a clear, complete record of their wishes that guides current and future care. This supports autonomy, informed decision-making, and ethical practice, while also providing legal protection by showing that the patient understood options and agreed to the plan. Documenting preferences and decisions alongside consent ensures the record tells the full story in one place—why a plan was chosen, what the patient agreed to, and how their goals shape the care plan. If you only document preferences when asked, or keep preferences out of notes, or store them separately, important context can be missed, leading to miscommunication, misaligned care, and fragmented records.

10. Which statement best describes the role of nonverbal communication in clinical encounters?

- A. It supports empathy and trust-building.**
- B. It replaces verbal explanations.
- C. It is used only with family members.
- D. It delays care.

Nonverbal communication in clinical encounters plays a foundational role in shaping how patients experience care. The most important function is to convey empathy, warmth, and confidence, which helps patients feel heard, understood, and safe. Simple cues like steady eye contact, an open posture, calm facial expressions, appropriate touch within professional boundaries, and a respectful tone can signal that you are attentive and genuinely concerned about the patient's well-being. These nonverbal signals work in tandem with verbal explanations, reinforcing trust and making patients more receptive to information and recommendations. They are not meant to replace what you say—clear, understandable verbal education remains essential. Nonverbal communication is used with all patients, not just family members, and when used well, it can facilitate smoother interactions rather than delay care.

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://personfirstlangcommbiasinphytherapy.examzify.com>

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

SAMPLE