

# PPC/OMM Block 8 Practice Exam (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. In craniosacral terminology, the anatomic barrier is described as which of the following?**
  - A. Anatomic barrier is the physiologic endpoint of motion**
  - B. They are completely separate concepts**
  - C. The physiologic endpoint is beyond the anatomic barrier**
  - D. The anatomic barrier is the starting point of motion**
  
- 2. An anterior Chapman point on the left iliotibial band near the splenic flexure corresponds to which colon region?**
  - A. Distal 3/5ths of the Transverse Colon**
  - B. Splenic Flexure and Descending Colon Middle Portion**
  - C. Sigmoid Area of the Colon**
  - D. Tonsils Between Rib 1 and 2 Adjacent to the Sternum**
  
- 3. Which statement correctly differentiates spondylolysis from spondylolisthesis?**
  - A. Spondylolysis is pars interarticularis fracture WITHOUT anterior displacement; Spondylolisthesis is pars interarticularis fracture WITH anterior displacement**
  - B. Spondylolysis is anterior displacement; Spondylolisthesis is posterior displacement**
  - C. Spondylolysis involves degenerative changes; Spondylolisthesis is fracture**
  - D. They are the same condition**
  
- 4. C2-C6 and C8-T1 SaRa are examples of anterior cervical tenderpoints.**
  - A. Anterior cervical tenderpoints**
  - B. Posterior cervical tenderpoints**
  - C. Thoracic tenderpoints**
  - D. Lumbar tenderpoints**
  
- 5. Which pulses should be checked in a patient with low back pain to assess possible vascular involvement?**
  - A. Dorsalis Pedis and Posterior Tibial**
  - B. Carotid and Radial**
  - C. Popliteal and Femoral**
  - D. Temporal and Brachial**

- 6. Spondylolysis is best described as?**
- A. Pars interarticularis fracture WITHOUT anterior displacement**
  - B. Pars interarticularis fracture WITH anterior displacement**
  - C. Degenerative changes of the spine**
  - D. Fracture of the vertebral body**
- 7. Which of the following ranges is associated with sympathetic innervation of GI organs proximal to the ligament of Treitz?**
- A. T1-T4**
  - B. T9-T11**
  - C. T5-T9**
  - D. T12-L2**
- 8. In the Roo's test, which action does the patient perform?**
- A. Abducts and flexes arms to 90 degrees and opens and closes hands for 3 minutes**
  - B. Raises arms to 45 degrees and holds breath**
  - C. Taps fingertips together rapidly**
  - D. Performs resisted shoulder external rotation**
- 9. If the L4 nerve root is damaged, which sensation is most likely lost?**
- A. Lateral aspect of leg and dorsum of foot**
  - B. Plantar surface of foot**
  - C. Medial aspect of leg and foot**
  - D. Dorsum of toes**
- 10. What are the signs and symptoms of spinal stenosis?**
- A. Pain worsened with extension**
  - B. Improved with forward leaning**
  - C. Pain, numbness, weakness radiating to lower legs**
  - D. All of the above**

## Answers

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

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## **Explanations**

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- 1. In craniosacral terminology, the anatomic barrier is described as which of the following?**
- A. Anatomic barrier is the physiologic endpoint of motion**
  - B. They are completely separate concepts**
  - C. The physiologic endpoint is beyond the anatomic barrier**
  - D. The anatomic barrier is the starting point of motion**

The main idea here is that two different limits govern how movement is described in craniosacral terminology: the anatomic barrier and the physiologic barrier. The anatomic barrier marks the physical end range of motion defined by the structures themselves. The physiologic barrier represents the functional end range that the body can achieve under normal, non-pathological conditions, taking into account tissue tolerance and neuromuscular factors. Why the given choice fits: saying that the physiologic endpoint is beyond the anatomic barrier captures the idea that the functional limit of motion (what you can achieve under physiologic conditions) lies beyond the purely anatomical limit. In practice, the anatomic barrier is the structural stop, while the physiologic endpoint reflects how far motion can be used or tolerated in a living, functioning system. This distinction emphasizes that a movement can still be considered within the realm of physiologic motion even as you approach or exceed purely passive, structural limits, depending on how motion is produced and tolerated by the tissues. For context, remember that the other statements imply either no separation between the concepts, or misplace the starting point or endpoint. The anatomic barrier is not simply the starting point of motion, and the two barriers are related but not identical concepts; they describe different limits, not the same thing.

- 2. An anterior Chapman point on the left iliotibial band near the splenic flexure corresponds to which colon region?**
- A. Distal 3/5ths of the Transverse Colon**
  - B. Splenic Flexure and Descending Colon Middle Portion**
  - C. Sigmoid Area of the Colon**
  - D. Tonsils Between Rib 1 and 2 Adjacent to the Sternum**

Chapman points map specific surface locations to particular visceral segments, so an anterior point on the body is used to assess and treat the corresponding part of the viscera. The left iliotibial band near the splenic flexure aligns with the area where the transverse colon ends and the descending colon begins, i.e., the splenic flexure and the middle portion of the descending colon. That surface spot is the reflex point for that exact stretch of colon, so it's the best match for issues arising in that region. The other options would correspond to different segments or structures not represented by that exact spot: the distal portion of the transverse colon sits higher up along the abdomen; the sigmoid colon is located lower in the left lower quadrant near the pelvis; and the tonsils point is unrelated to the colon and lies near the sternum.

**3. Which statement correctly differentiates spondylolysis from spondylolisthesis?**

- A. Spondylolysis is pars interarticularis fracture WITHOUT anterior displacement; Spondylolisthesis is pars interarticularis fracture WITH anterior displacement**
- B. Spondylolysis is anterior displacement; Spondylolisthesis is posterior displacement**
- C. Spondylolysis involves degenerative changes; Spondylolisthesis is fracture**
- D. They are the same condition**

The main idea is the presence or absence of forward (anterior) displacement of a vertebra. Spondylolysis is a stress fracture of the pars interarticularis with no relative anterior displacement—the bone defect exists but the vertebra doesn't slip. Spondylolisthesis, on the other hand, involves forward slippage of a vertebral body relative to the one below, usually due to a bilateral pars defect that allows the slip. So the statement that distinguishes them is that spondylolysis is a pars fracture without anterior displacement, while spondylolisthesis is a pars fracture with anterior displacement. This isn't about degenerative changes, and they aren't the same condition—spondylolysis can be present with no listhesis, whereas listhesis signifies actual vertebral displacement.

**4. C2-C6 and C8/T8 are examples of anterior cervical tenderpoints.**

- A. Anterior cervical tenderpoints**
- B. Posterior cervical tenderpoints**
- C. Thoracic tenderpoints**
- D. Lumbar tenderpoints**

These tenderpoints are located on the front of the neck over the cervical spine levels. Anterior placement is what defines them as anterior cervical tenderpoints, distinguishing them from posterior cervical points (on the back of the neck) and from thoracic or lumbar points (in the mid-back or lower back). In osteopathic practice, identifying these anterior neck sites helps target treatment with techniques that address dysfunction in the cervical region.

**5. Which pulses should be checked in a patient with low back pain to assess possible vascular involvement?**

**A. Dorsalis Pedis and Posterior Tibial**

**B. Carotid and Radial**

**C. Popliteal and Femoral**

**D. Temporal and Brachial**

When assessing back pain for possible vascular involvement, you want a quick read on the blood flow to the legs, which reflects how well the abdominal aorta and its branches are delivering blood downstream. The most practical and informative pulses to check are the dorsalis pedis pulse on the top of the foot and the posterior tibial pulse behind the ankle. These two distal pulses give you a direct sense of distal arterial perfusion and help you detect signs of vascular disease or acute aortic problems that could be causing the back pain. It's also easy to compare them on both sides, which helps identify asymmetry that might indicate a vascular issue. Carotid and radial pulses assess upper-body circulation and systemic atherosclerosis but don't directly reflect lower-extremity perfusion relevant to back-pain vascular concerns. Popliteal and femoral pulses are valid checks as well, but they're less accessible and distal pulses on the feet are typically the most informative for the scenario described.

**6. Spondylolysis is best described as?**

**A. Pars interarticularis fracture WITHOUT anterior displacement**

**B. Pars interarticularis fracture WITH anterior displacement**

**C. Degenerative changes of the spine**

**D. Fracture of the vertebral body**

Spondylolysis is a stress fracture of the pars interarticularis, usually in the lumbar spine (often L5) in young athletes. It is defined by a fracture in the pars interarticularis with no forward movement of the vertebra itself. That lack of anterior displacement is what distinguishes it from spondylolisthesis, where the affected vertebra slips forward. When the pars defect is bilateral, it can progress to spondylolisthesis, but isolated spondylolysis remains without displacement. This is why the description of a pars interarticularis fracture without anterior displacement best fits. Degenerative changes involve wear-and-tear changes, not a pars fracture; fracture of the vertebral body is a different injury (like a compression fracture); and an anteriorly displaced fracture would describe a scenario closer to spondylolisthesis rather than spondylolysis.

**7. Which of the following ranges is associated with sympathetic innervation of GI organs proximal to the ligament of Treitz?**

- A. T1-T4
- B. T9-T11
- C. T5-T9**
- D. T12-L2

The key idea is that foregut structures (proximal to the ligament of Treitz) get sympathetic input mainly from the greater splanchnic nerve, which originates from spinal levels T5 through T9. These preganglionic fibers ascend to the celiac ganglion, synapse there, and postganglionic fibers ride along the celiac trunk to innervate the stomach, liver, pancreas, spleen, and proximal duodenum. So this T5-T9 range precisely matches the sympathetic supply to those foregut organs. Other ranges correspond to different regions: higher levels relate to head/neck and upper limbs, while T9-T12 or T12-L2 align with midgut and hindgut via lesser and lumbar splanchnic nerves.

**8. In the Roo's test, which action does the patient perform?**

- A. Abducts and flexes arms to 90 degrees and opens and closes hands for 3 minutes**
- B. Raises arms to 45 degrees and holds breath
- C. Taps fingertips together rapidly
- D. Performs resisted shoulder external rotation

Roos test is a provocative maneuver for thoracic outlet syndrome. The patient positions the arms abducted to about 90 degrees with the elbows bent to 90 degrees, then repeatedly opens and closes the fists for about 3 minutes. This sustained, repetitive action stresses the neurovascular structures between the clavicle and first rib, so if there's compression, symptoms such as numbness, weakness, fatigue, or pallor can appear. The described action matches this exact setup—abducting and flexing the arms to 90 degrees and opening and closing the hands for several minutes. The other options describe different tests or tasks that don't provoke thoracic outlet symptoms in the same way.

**9. If the L4 nerve root is damaged, which sensation is most likely lost?**

- A. Lateral aspect of leg and dorsum of foot
- B. Plantar surface of foot
- C. Medial aspect of leg and foot**
- D. Dorsum of toes

L4 dermatome covers the medial aspect of the leg and foot, so when the L4 nerve root is damaged, sensory loss is most likely felt there. That medial leg/foot region is the hallmark region supplied by L4, making it the best answer. The lateral leg and dorsum of the foot are more associated with other roots (like L5), the plantar surface of the foot with S1/S2, and the dorsum of the toes with L5, so those areas would be less likely to be affected by L4 injury.

**10. What are the signs and symptoms of spinal stenosis?**

- A. Pain worsened with extension**
- B. Improved with forward leaning**
- C. Pain, numbness, weakness radiating to lower legs**
- D. All of the above**

Spinal stenosis narrows the spinal canal and compresses nerve roots, leading to neurogenic claudication and radicular symptoms. The canal compression tends to worsen with extension (standing upright) and improve when the spine is flexed or leaned forward, which opens the canal. Nerve compression also produces pain, numbness, and weakness that can radiate down into the lower legs. Since each statement aligns with how stenosis presents, the best answer is all of the above.

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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](mailto:hello@examzify.com).**

**Or visit your dedicated course page for more study tools and resources:**

**<https://ppcommblock8.examzify.com>**

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

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