

Senior Practicum Basic Physical Assessment Practice Test (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. What are the components of a neurological assessment?**
 - A. Heart rate, blood pressure, and temperature**
 - B. Level of consciousness, pupil response, motor function, sensory function, and reflexes**
 - C. Respiratory rate, lung capacity, and oxygen saturation**
 - D. Muscle strength, range of motion, and endurance**

- 2. How is abdominal tenderness typically assessed?**
 - A. By auscultating the abdomen for bowel sounds**
 - B. By gently palpating the abdomen**
 - C. By observing the abdomen for swelling**
 - D. By percussing the abdomen for sounds**

- 3. How does the nurse elicit rebound tenderness in a patient suspected of having peritonitis?**
 - A. Applying light pressure and maintaining contact**
 - B. Gently massaging the abdomen in a circular motion**
 - C. Pressing firmly on the affected area and quickly releasing**
 - D. Palpating the abdomen deeply in a rhythmic pattern**

- 4. When a client presents with a combative behavior due to substance use, what is the nurse's priority action?**
 - A. Start intravenous sedation**
 - B. Complete a thorough assessment**
 - C. Call a family member for assistance**
 - D. Refer to an addiction team immediately**

- 5. What is the role of auscultation in a respiratory assessment?**
 - A. To assess the strength of respiratory muscles**
 - B. To identify abnormal lung sounds**
 - C. To measure breathing rate**
 - D. To check for abdominal distension**

6. Which data indicate a problem when assessing a client's respiratory status?

- A. Respiratory rate of 20 breaths/min and deep breaths**
- B. Respiratory rate of 14 breaths/min and normal sounds**
- C. Respiratory rate of 28 breaths/min and audible wheezing**
- D. Respiratory rate of 16 breaths/min and regular pattern**

7. Which technique is best for measuring blood pressure to avoid inaccurate readings?

- A. Using a stethoscope in both ears**
- B. Rapidly inflating the cuff until the pulse is undetectable**
- C. Measuring in both arms simultaneously**
- D. Palpating before auscultating to confirm systolic pressure**

8. Name a tool used to assess pain during a physical assessment.

- A. The Visual Analog Scale**
- B. The Blood Pressure Cuff**
- C. The Glucometer**
- D. The ECG Monitor**

9. During the inspection phase of a physical assessment, the observer looks for which of the following?

- A. Internal organ functionality**
- B. Physical characteristics such as color and shape**
- C. Emotional state of the patient**
- D. Genetic predispositions**

10. What complication should a nurse prioritize for a client on complete bed rest?

- A. Sepsis**
- B. Thrombophlebitis**
- C. Pneumonia**
- D. Pressure ulcers**

Answers

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

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Explanations

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1. What are the components of a neurological assessment?

- A. Heart rate, blood pressure, and temperature
- B. Level of consciousness, pupil response, motor function, sensory function, and reflexes**
- C. Respiratory rate, lung capacity, and oxygen saturation
- D. Muscle strength, range of motion, and endurance

The components of a neurological assessment focus specifically on evaluating the nervous system's function and detecting any abnormalities or issues. This includes assessing the level of consciousness, which indicates how alert and aware a person is; pupil response, which examines how the pupils react to light and provides insight into brain function; motor function, which evaluates movement and coordination; sensory function, which tests the ability to feel sensations such as touch, pain, and temperature; and reflexes, which are involuntary responses that can reveal the integrity of the nervous system pathways. This systematic approach provides healthcare providers with crucial information about the patient's neurological status, helping to identify problems such as strokes, head injuries, or other neurological conditions. The other options listed present assessments related to different systems of the body - cardiovascular, respiratory, and musculoskeletal - which, while important, are not part of the neurological assessment specifically.

2. How is abdominal tenderness typically assessed?

- A. By auscultating the abdomen for bowel sounds
- B. By gently palpating the abdomen**
- C. By observing the abdomen for swelling
- D. By percussing the abdomen for sounds

Abdominal tenderness is typically assessed by gently palpating the abdomen. This technique involves the healthcare provider using their hands to press on the abdominal region, which allows them to feel for any abnormal reactions or pain responses from the patient. When pressure is applied during palpation, the provider can observe the patient's facial expressions and body language, which may indicate tenderness or discomfort. Palpation can help to identify various conditions, such as organ enlargement, masses, or areas of acute discomfort that might suggest underlying issues like inflammation or injury. By being gentle and specifically focused on areas where the patient reports pain, the clinician can gather essential information regarding the patient's abdominal health. Other methods, such as auscultation for bowel sounds, observation for swelling, or percussion for sounds, are not sufficient for assessing tenderness because they do not involve the direct interaction with the abdomen that palpation provides. Tenderness is a subjective experience and is best assessed through a physical examination approach that enables the clinician to elicit a pain response.

3. How does the nurse elicit rebound tenderness in a patient suspected of having peritonitis?

- A. Applying light pressure and maintaining contact**
- B. Gently massaging the abdomen in a circular motion**
- C. Pressing firmly on the affected area and quickly releasing**
- D. Palpating the abdomen deeply in a rhythmic pattern**

Rebound tenderness is a clinical sign that indicates irritation of the peritoneum, often associated with conditions like peritonitis. To elicit rebound tenderness, the nurse presses firmly on the abdomen, particularly over the area that is suspected to be inflamed or painful. After applying pressure, the nurse quickly releases the hand. This sudden release causes the peritoneum to react, which can cause the patient to experience sharp pain as the pressure is removed. This reaction occurs because the inflammation leads to heightened sensitivity in the peritoneal area, so the rapid change in pressure during the release of the applied force brings about the characteristic pain of rebound tenderness. The other techniques mentioned do not specifically assess for rebound tenderness. Light pressure with maintained contact does not produce the sudden change in pressure needed to elicit a response. Circular massage may relax the abdominal muscles but does not apply the necessary force to test for tenderness effectively. Deep, rhythmic palpation might help assess organ size or tenderness but lacks the specific intent necessary to identify rebound tenderness. Therefore, the technique of pressing firmly and then rapidly releasing is a crucial assessment method for evaluating potential peritoneal irritation.

4. When a client presents with a combative behavior due to substance use, what is the nurse's priority action?

- A. Start intravenous sedation**
- B. Complete a thorough assessment**
- C. Call a family member for assistance**
- D. Refer to an addiction team immediately**

In situations where a client exhibits combative behavior due to substance use, the nurse's priority action should be to complete a thorough assessment. This approach is crucial because it allows the nurse to gather essential information about the client's condition, which could include the type and amount of substance used, any underlying medical issues, and the extent of their behavioral changes. Understanding the specific circumstances of the client's behavior helps in determining the safest and most effective interventions. A comprehensive assessment ensures that the nurse is equipped to identify potential risks, including harm to the client or others, and to tailor an appropriate care plan. It provides a foundation for evaluating whether immediate sedation or intervention is necessary and assists in making informed decisions about calling for additional support, such as family members or addiction services. By focusing on assessment first, the nurse can implement the safest care strategies, prioritize the client's physical and emotional well-being, and effectively collaborate with other healthcare professionals as needed.

5. What is the role of auscultation in a respiratory assessment?

- A. To assess the strength of respiratory muscles
- B. To identify abnormal lung sounds**
- C. To measure breathing rate
- D. To check for abdominal distension

Auscultation plays a critical role in respiratory assessment by allowing healthcare professionals to listen to the sounds produced within the lungs. This technique is essential for identifying abnormal lung sounds, which can provide valuable insights into the patient's respiratory health. Normal lung sounds indicate proper airflow and functioning of the lungs, while abnormal sounds—such as wheezing, crackles, or absence of breath sounds—can suggest various respiratory conditions like asthma, pneumonia, or lung obstruction. By focusing on the sounds during auscultation, clinicians can detect issues that may not be apparent through visual inspection or patient history alone. Identifying these abnormalities is crucial for diagnosing respiratory diseases and informing treatment decisions, making it an indispensable part of a thorough physical assessment.

6. Which data indicate a problem when assessing a client's respiratory status?

- A. Respiratory rate of 20 breaths/min and deep breaths
- B. Respiratory rate of 14 breaths/min and normal sounds
- C. Respiratory rate of 28 breaths/min and audible wheezing**
- D. Respiratory rate of 16 breaths/min and regular pattern

A respiratory rate of 28 breaths per minute, combined with audible wheezing, clearly indicates a problem in a client's respiratory status. A normal respiratory rate for adults typically ranges from 12 to 20 breaths per minute. When breathing exceeds this range, it can signify tachypnea, which may indicate respiratory distress or a potential underlying condition. Audible wheezing allows for further evaluation of the client's airway — it suggests that there may be bronchoconstriction or the presence of mucus blocking the airways, both of which can impede normal airflow and lead to compromised oxygenation. Other options reflect respiratory rates that fall within the normal range or are accompanied by normal sounds and patterns, indicating that those clients are likely stable.

7. Which technique is best for measuring blood pressure to avoid inaccurate readings?

- A. Using a stethoscope in both ears**
- B. Rapidly inflating the cuff until the pulse is undetectable**
- C. Measuring in both arms simultaneously**
- D. Palpating before auscultating to confirm systolic pressure**

Rapidly inflating the cuff until the pulse is undetectable is an effective technique to ensure accurate blood pressure readings. This method allows the practitioner to quickly reach a point where the pressure in the cuff exceeds the systolic pressure, which is critical for accurate measurements. Inflating quickly prevents fluctuations or movements that could lead to inaccuracies and helps establish a clear baseline before gradually deflating the cuff to listen for the Korotkoff sounds. This technique is particularly beneficial because it minimizes discomfort for the patient and reduces the risk of extraneous factors, such as variations in heart rate or respiratory patterns, which could occur if inflation is done too slowly. By avoiding prolonged inflation time, the risk of the patient becoming anxious or uncomfortable is lessened, promoting a more reliable reading. The other techniques mentioned may not address the key factors that contribute to inaccuracies in blood pressure measurement, such as differences in arm size, vessel compression, or variations in technique. Focusing on a swift inflation while confirming the baseline pressure enhances the reliability of the blood pressure assessment.

8. Name a tool used to assess pain during a physical assessment.

- A. The Visual Analog Scale**
- B. The Blood Pressure Cuff**
- C. The Glucometer**
- D. The ECG Monitor**

The Visual Analog Scale is a widely used tool for assessing pain levels during a physical assessment. It typically consists of a straight line with endpoints that represent the extreme feelings of pain: one end indicates "no pain" and the other end indicates "worst pain imaginable." Patients mark a point on the line that corresponds to their pain level, allowing healthcare professionals to quantify and communicate the intensity of the patient's pain. Using this scale is beneficial because it's straightforward and can be easily understood by patients, allowing them to express their pain in a visual manner. It can also facilitate better pain management decisions by providing a clear measurement of the patient's pain over time and in response to treatment. The other options listed do not serve the purpose of assessing pain. A blood pressure cuff measures blood pressure, a glucometer measures blood glucose levels, and an ECG monitor records the electrical activity of the heart. None of these tools provide a direct assessment of pain, which underscores why the Visual Analog Scale is the appropriate choice.

9. During the inspection phase of a physical assessment, the observer looks for which of the following?

- A. Internal organ functionality**
- B. Physical characteristics such as color and shape**
- C. Emotional state of the patient**
- D. Genetic predispositions**

During the inspection phase of a physical assessment, the primary focus is on observing physical characteristics such as color, shape, size, and overall appearance. This method of assessment allows for a visual examination of the patient, enabling the practitioner to identify any abnormalities or characteristics that may indicate underlying health issues. Observations may include the patient's skin color, which can provide insights into their oxygenation and circulation; the shape of limbs or body parts, which could signal possible deformities or changes; and any visible lesions or markings that might require further investigation. This phase is critical because it establishes a foundational understanding of the patient's condition before further assessments, such as palpation or auscultation, take place. The other options focus on aspects that are not typically observed directly during the inspection phase. While understanding organ functionality is important for overall assessment, it's evaluated through other means, like diagnostic tests. The emotional state of the patient might be inferred through observed behaviors or expressions, but is not the focus of the physical inspection itself. Additionally, genetic predispositions are not visible characteristics but rather background information that may influence health and are not assessed through visual inspection alone.

10. What complication should a nurse prioritize for a client on complete bed rest?

- A. Sepsis**
- B. Thrombophlebitis**
- C. Pneumonia**
- D. Pressure ulcers**

For a client on complete bed rest, prioritizing the risk of thrombophlebitis is critical due to the implications of prolonged immobility. When a patient remains in one position for an extended period, the blood flow can slow down, increasing the likelihood of clot formation in the veins, particularly in the legs. This condition is further exacerbated if there are underlying risk factors such as dehydration, surgery, or history of venous thromboembolism. While other complications, such as pneumonia, sepsis, and pressure ulcers are significant, the immediate and potentially life-threatening nature of thrombophlebitis makes it essential to monitor for this condition. Thrombophlebitis can lead to deep vein thrombosis (DVT) and even pulmonary embolism (PE) if clots dislodge and travel to the lungs. These risks highlight why thrombophlebitis should be considered a higher priority in patients confined to bed rest since it requires prompt intervention to prevent more severe complications.

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://srpracticumbasicphysassmt.examzify.com>

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

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