

SENIOR PRACTICUM BASIC PHYSICAL ASSESSMENT PRACTICE TEST (SAMPLE) STUDY GUIDE



SAMPLE STUDY GUIDE WITH LIMITED QUESTIONS

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THE FULL VERSION STUDY GUIDE**

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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

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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 is indicated by a tight and painful lump in the breast?**
 - A. Typical of fibrocystic breast disease.
 - B. Likely to be a malignant tumor.
 - C. Often resolves with menstrual changes.
 - D. Common in younger women.
- 2. What does phrenic nerve involvement primarily affect in a client?**
 - A. Urinary elimination
 - B. Breathing pattern
 - C. Cardiovascular function
 - D. Muscle movement
- 3. If a nurse observes redness, swelling, and induration at a surgical wound site, what should be the next action?**
 - A. Apply a new dressing to the wound
 - B. Administer pain medication
 - C. Assess the client's temperature
 - D. Notify the healthcare provider immediately
- 4. What action should the nurse take to avoid recording a low systolic blood pressure when there's an auscultatory gap?**
 - A. Inflate the cuff at least 20 mm Hg above the radial pulse
 - B. Inflate the cuff at least another 30 mm Hg after losing pulse
 - C. Document the low reading and retake later
 - D. Check the blood pressure in both arms at once
- 5. What is the most appropriate response by the nurse to a Latino client exhibiting restlessness and refusing dinner?**
 - A. "Are you feeling alright?"
 - B. "Do you need pain medication?"
 - C. "Tell me what you are feeling."
 - D. "Why aren't you eating?"

- 6. Which vital sign is NOT typically measured during a basic physical assessment?**
- A. Body temperature
 - B. Pulse rate
 - C. Blood glucose level
 - D. Respiratory rate
- 7. Which pulse site should a nurse palpate to assess the effectiveness of cardiac compressions during adult CPR?**
- A. Radial
 - B. Brachial
 - C. Carotid
 - D. Femoral
- 8. What does palpation help assess during a physical assessment?**
- A. Heart sounds
 - B. Body temperature and texture
 - C. Visual abnormalities
 - D. Patient's emotional response
- 9. Which factor is most important when assessing skin turgor in elderly individuals?**
- A. Age-related skin changes
 - B. Recent fluid intake
 - C. Skin color
 - D. Environmental conditions
- 10. What is the primary focus when assessing an older adult's skin?**
- A. Identifying skin turgor
 - B. Noting changes from normal findings
 - C. Checking for wrinkles
 - D. Comparing skin color between extremities

Answers

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

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Explanations

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1. What is indicated by a tight and painful lump in the breast?

- A. Typical of fibrocystic breast disease.
- B. Likely to be a malignant tumor.**
- C. Often resolves with menstrual changes.
- D. Common in younger women.

A tight and painful lump in the breast can indeed raise concerns about potential breast pathology. When the lump is described as tight and painful, these characteristics can be indicative of various conditions, one of which may warrant further investigation for malignancy. Breast cancer can present as a palpable mass that is hard or firm and may be associated with sensation changes in the surrounding tissue, including pain. While some lumps may be benign, such as those found in fibrocystic breast disease or other non-cancerous conditions, the specifics of the lump's characteristics—tightness and pain—often align more closely with a malignant process, particularly when there are no other benign features present. Thus, considering the clinical significance and the need for further evaluation, it is critical to investigate such findings promptly. Understanding the other possibilities, fibrocystic breast disease often presents with multiple lumps that can fluctuate with hormonal changes, typically leading to less localized and less pronounced pain. Similarly, many types of benign breast changes, such as cysts or fibroadenomas, may not cause significant discomfort or tightness. Additionally, while breast lumps are indeed common in younger women, they do not specifically indicate malignancy without further evidence. Hence, the emphasis on the characteristics of the lump is

2. What does phrenic nerve involvement primarily affect in a client?

- A. Urinary elimination
- B. Breathing pattern**
- C. Cardiovascular function
- D. Muscle movement

The phrenic nerve is crucial for the control of breathing because it innervates the diaphragm, the primary muscle involved in respiration. When the phrenic nerve is functioning normally, it sends signals from the brain to the diaphragm, prompting it to contract and expand during inhalation and exhalation. If there is involvement or impairment of the phrenic nerve, the diaphragm may not function properly, leading to significant difficulties in the breathing pattern. Involvement of the phrenic nerve may result in conditions such as diaphragmatic paralysis or respiratory distress, as the ability to effectively inhale and exhale air is compromised. This can manifest as shortness of breath or an inadequate volume of air being moved in and out of the lungs, thus directly impacting a client's respiratory status. The other options focus on body systems that are influenced by different nerves and pathways. For instance, while urinary elimination and muscle movement can be affected by other nerves, they are not primarily influenced by the phrenic nerve. Cardiovascular function is also independently managed by different sets of nerves and has its own regulatory mechanisms. Therefore, phrenic nerve involvement is specifically related to breathing patterns and respiratory function.

3. If a nurse observes redness, swelling, and induration at a surgical wound site, what should be the next action?

- A. Apply a new dressing to the wound
- B. Administer pain medication
- C. Assess the client's temperature**
- D. Notify the healthcare provider immediately

In the context of observing redness, swelling, and induration at a surgical wound site, assessing the client's temperature is crucial as these signs may indicate an infection or an inflammatory response. A temperature assessment can help determine whether there is an elevated body temperature, which is a common indicator of infection. Monitoring vital signs, particularly temperature, allows healthcare providers to gain vital information about the patient's condition. If the temperature is elevated, it would further support the suspicion of infection and prompt further interventions. The absence of fever does not completely rule out infection, but it provides an important data point for the overall assessment. Other options, while they may seem relevant, can be secondary actions. Applying a new dressing without first understanding the extent of the problem may not address the underlying issue. Administering pain medication does not tackle the potential source of the problem either, and notifying the healthcare provider might be premature without first collecting further information through assessment. Therefore, assessing the temperature serves as an essential first step in responding appropriately to the observed signs at the surgical wound site.

4. What action should the nurse take to avoid recording a low systolic blood pressure when there's an auscultatory gap?

- A. Inflate the cuff at least 20 mm Hg above the radial pulse
- B. Inflate the cuff at least another 30 mm Hg after losing pulse**
- C. Document the low reading and retake later
- D. Check the blood pressure in both arms at once

When assessing blood pressure, an auscultatory gap refers to a period during which no sound is heard while listening through the stethoscope as the cuff pressure is released. This can lead to an inaccurate reading, specifically a falsely low systolic blood pressure. To ensure that the nurse accurately captures the systolic blood pressure when an auscultatory gap is present, it is crucial to inflate the cuff sufficiently above the last palpable radial pulse. By inflating the cuff at least another 30 mm Hg after losing the pulse, the nurse ensures that the cuff pressure is high enough to account for the gap and obtain an accurate reading once sounds reappear. This practice helps prevent the error of recording a systolic pressure that is lower than the actual value, which is essential for proper patient assessment and treatment planning. In this context, the other suggested actions do not effectively address the issue of the auscultatory gap in the same way. For instance, inflating the cuff 20 mm Hg above the radial pulse may not provide enough pressure to bypass the gap, while documenting a low reading and retaking it later does not correct the potential for miscalculation at the time of the initial assessment. Checking blood pressure in both arms at once does not directly correlate

5. What is the most appropriate response by the nurse to a Latino client exhibiting restlessness and refusing dinner?

- A. "Are you feeling alright?"
- B. "Do you need pain medication?"
- C. "Tell me what you are feeling."**
- D. "Why aren't you eating?"

Choosing to respond with "Tell me what you are feeling" aligns well with fostering communication and understanding in a clinical setting, especially when caring for a client who may be expressing discomfort or distress through non-verbal cues like restlessness and refusing food. This approach invites the client to share their feelings and thoughts, which can provide valuable insights into their emotional or physical state, and encourages an open dialogue about their concerns. Engaging the client in conversation allows the nurse to assess potential underlying issues, such as cultural influences on eating behaviors, emotional distress, or specific health concerns. It emphasizes an empathetic approach that respects the client's voice and encourages them to articulate their needs, which is vital for personalized care. In experiencing restlessness and a refusal to eat, the client could be dealing with a range of issues—perhaps stress, anxiety, cultural preferences, or health-related concerns—not all of which may be readily apparent. This response promotes a therapeutic relationship, helping to ensure that the client's needs are adequately understood and addressed.

6. Which vital sign is NOT typically measured during a basic physical assessment?

- A. Body temperature
- B. Pulse rate
- C. Blood glucose level**
- D. Respiratory rate

In a basic physical assessment, blood glucose level is not typically classified as a vital sign. Vital signs primarily include body temperature, pulse rate, blood pressure, and respiratory rate. These measurements serve as key indicators of a person's physiological status and are essential in evaluating immediate health and detecting potential medical issues. Body temperature provides information about the body's thermoregulation. Pulse rate offers insights into cardiovascular health, whereas respiratory rate reflects lung and overall respiratory function. Blood glucose level, while important in assessing metabolic status, is not a vital sign; it is usually measured separately, particularly in patients at risk for diabetes or in those presenting with symptoms suggestive of hypoglycemia or hyperglycemia. Therefore, while monitoring blood glucose is crucial in specific clinical situations, it does not fall under the traditional category of vital signs assessed during a routine physical examination.

7. Which pulse site should a nurse palpate to assess the effectiveness of cardiac compressions during adult CPR?

- A. Radial
- B. Brachial
- C. Carotid**
- D. Femoral

The carotid pulse is the most appropriate site for assessing the effectiveness of cardiac compressions during adult CPR. This is primarily because the carotid artery is located centrally and deeply within the body, making it more likely to be palpable when perfusion is restored to the brain after effective compressions. During CPR, the goal is to maintain blood flow to vital organs, especially the brain and heart, and palpating the carotid pulse allows the healthcare provider to quickly assess the return of adequate circulation. In this context, the effectiveness of compressions is evaluated by checking for a pulse that indicates that blood is being expelled from the heart and reaching the carotid arteries. This is critical because if there is no pulse palpable at the carotid site after sufficient compressions, it may indicate that the compressions are not effective, and further interventions may be necessary. Other pulse sites, while useful in different clinical scenarios, may not provide the same immediate and reliable information about cardiac output during CPR interventions. For instance, the radial pulse is more peripheral and may not be detectable if blood flow is compromised. The brachial pulse is similarly located in an area where blood flow may not be easily assessed during emergencies. The femoral pulse, although central, is less accessible during

8. What does palpation help assess during a physical assessment?

- A. Heart sounds
- B. Body temperature and texture**
- C. Visual abnormalities
- D. Patient's emotional response

Palpation is a physical examination technique that involves using the hands to feel various parts of the body. This method is particularly effective in assessing body temperature and texture. When a healthcare provider palpates an area, they can detect warmth or coolness, which can indicate inflammation or infection. Additionally, palpation allows for the assessment of the texture of the skin or underlying tissues, such as identifying areas that are smooth, rough, or lumpy, which can provide important diagnostic clues regarding the patient's health. While heart sounds are typically assessed through auscultation—listening to the body with a stethoscope—visual abnormalities are observed through inspection. The patient's emotional response is also assessed through interaction and observation rather than palpation. Therefore, palpation is specifically relevant for evaluating body temperature and texture, making it a key technique in physical assessments.

9. Which factor is most important when assessing skin turgor in elderly individuals?

- A. Age-related skin changes**
- B. Recent fluid intake
- C. Skin color
- D. Environmental conditions

When assessing skin turgor in elderly individuals, age-related skin changes are the most significant factor to consider. As people age, their skin undergoes various physiological changes, including loss of elasticity and moisture. This results in a decreased ability of the skin to return to its normal position after being pinched. Assessing skin turgor provides insight into a person's hydration status, but in the elderly, the inherent changes in skin structure due to aging can provide misleading information if not considered. Understanding these age-related changes helps healthcare professionals accurately interpret the skin's appearance and its reaction when tested for turgor. In older adults, the skin tends to remain tented for longer periods due to reduced collagen and elastin levels, making it essential to account for these factors in the assessment process. While other factors like recent fluid intake, skin color, and environmental conditions can influence skin turgor, they do not specifically address the unique modifications that aging brings to skin physiology that directly impact the assessment.

10. What is the primary focus when assessing an older adult's skin?

- A. Identifying skin turgor
- B. Noting changes from normal findings**
- C. Checking for wrinkles
- D. Comparing skin color between extremities

The primary focus when assessing an older adult's skin is noting changes from normal findings. This approach is crucial because the skin undergoes various changes with aging, including decreased elasticity, dryness, thinning, and increased pigmentation. Recognizing these changes helps healthcare providers identify possible issues or skin conditions that may require further investigation or intervention. By observing deviations from baseline or expected skin characteristics, practitioners can detect signs of aging that might indicate underlying health problems. For instance, sudden changes in pigmentation could suggest conditions like skin cancer, while loss of turgor is critical in assessing hydration status but may not reflect the full spectrum of skin health. Thus, tracking changes in appearance is essential for proper diagnosis and care in older adults. Understanding the significance of changes allows for more effective monitoring and management of skin health, which is particularly vital in this population due to their susceptibility to skin-related issues.

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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