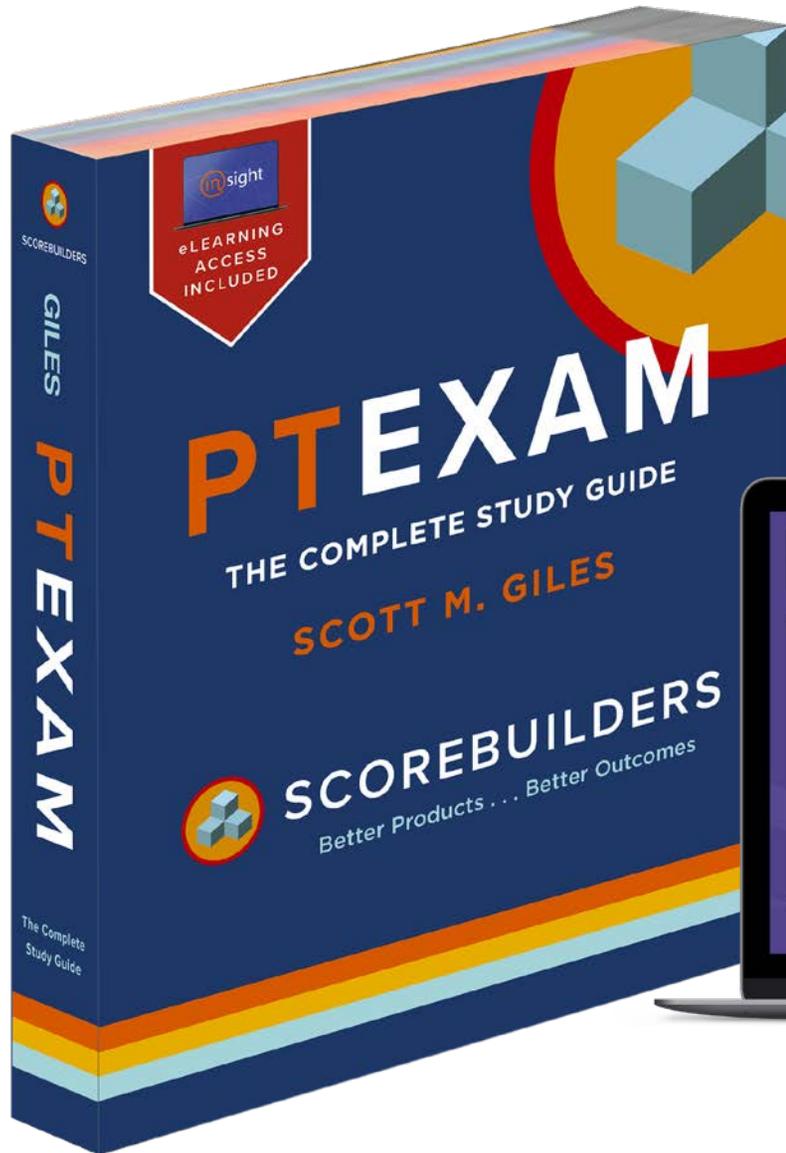
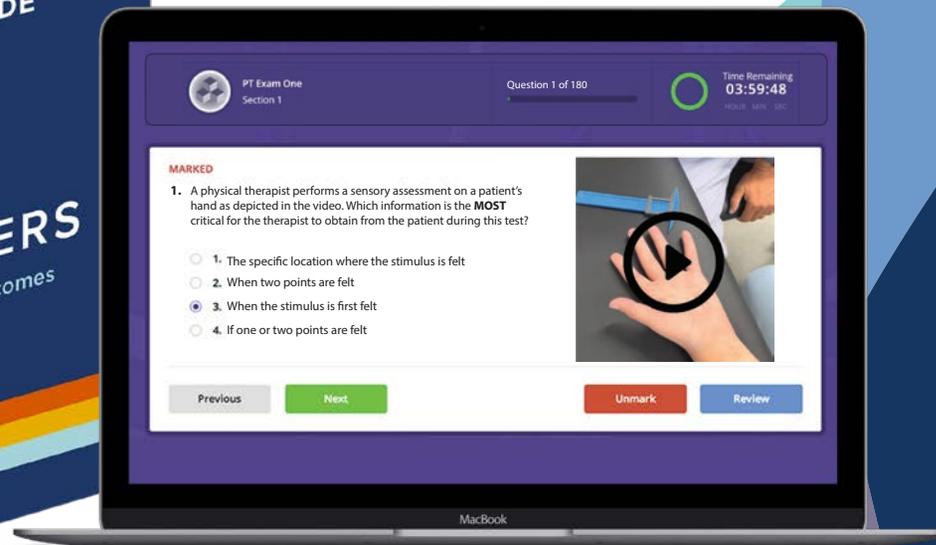


# PTEXAM THE COMPLETE STUDY GUIDE

## VIEWBOOK

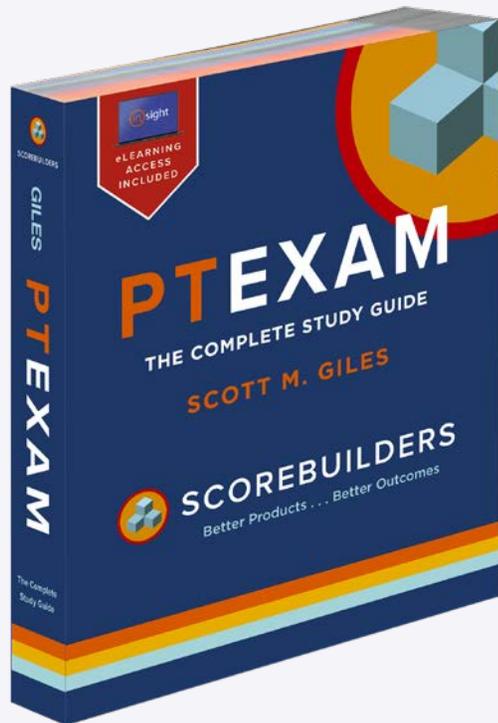


Updated  
for 2024  
NPTE-PT  
Blueprint!



# The Gold Standard

Explore our viewbook to discover why Scorebuilders' **PTEXAM: The Complete Study Guide** sets a new standard in review book excellence.



**PTEXAM: The Complete Study Guide** is the most comprehensive resource available for the NPTE-PT. The resource includes a **complete academic review** and the **most realistic sample exams** available.

**Author:** Scott Giles PT, DPT, MBA

**Pages:** 1216

**ISBN:** 978-1890989-46-0

**Price:** \$99.00



The review book purchase includes access to **Insight**, which contains 540 clinically-oriented questions and detailed explanations of the correct and incorrect answers. Students have the ability to create custom exams and compare their results to other students in a variety of system and content outline areas.

# We're Ready for the 2024 Blueprint Change - Are You?

Scorebuilders has been hard at work to ensure you have the latest and greatest information for the NPTE-PT!



## New Academic Content Additions

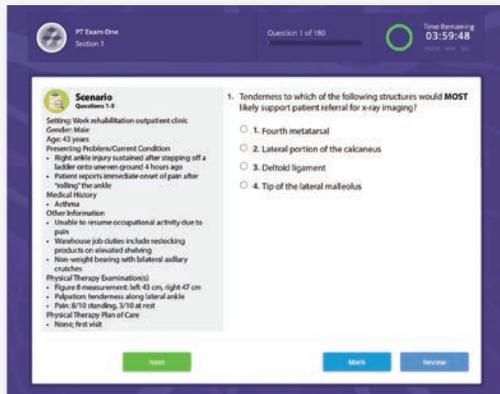
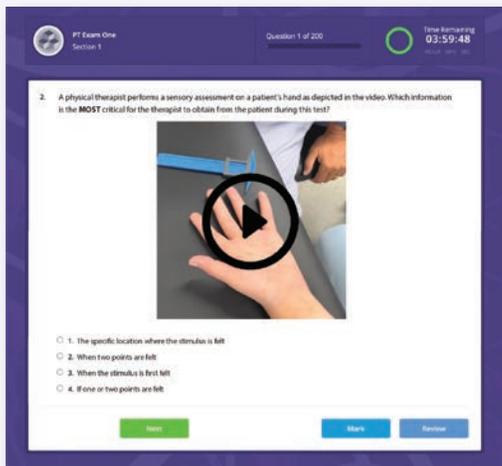
Neurological Rehabilitation  
Pediatrics  
Clinical Practice Guidelines  
Clinical Prediction Rules  
Telehealth  
Long-COVID  
Plus much more!

## Video Questions

This type of question consists of traditional text with a short video that provides students with important information and contextual clues necessary to answer exam questions.

## Scenario Questions

This type of question consists of a standardized patient scenario that provides information on patient characteristics, pertinent medical history, and current symptoms. Students will be required to answer questions that rely on the specific information presented in the patient scenario.



# Content is King

PTEXAM: The Complete Study Guide's academic review section is unparalleled in its breadth and depth. We don't try to teach students everything there is to know about physical therapy - only the information and strategies they will need to pass the examination.

702 Unit 2 | Academic Review

### Ambulation

**Assistive Devices**

Primary indications for using an assistive device during ambulation include:

- Decreased weight bearing on the lower extremities
- Muscular weakness of the trunk or lower extremities
- Decreased balance or impaired kinesthetic awareness
- Pain

**Assistive Device Selection<sup>108</sup>**

**Parallel Bars**

Parallel bars provide maximum stability and security for a patient during the beginning stages of ambulation or standing. Proper fit includes bar height that allows for 20-25 degrees of elbow flexion while grasping on the bars approximately 10 to 15 inches in front of the body. A patient must progress out of the parallel bars as quickly as possible to increase neural excitability and decrease dependence upon the parallel bars.

**Walkers**

A walker can be used with all levels of weight bearing. The walker has a significant base of support and offers good stability (Fig. 8-21). The walker should allow for 20-25 degrees of elbow flexion to ensure proper fit. The standard walker has many variations including rolling, fixed, rear-wheel, folding, or adjustable walker with brakes, upper extremity attachments and/or a seat platform. The walker is used with a three-point gait pattern.

**Auxiliary Crutches**

Auxiliary crutches can be used with all levels of weight bearing, however, require higher coordination for proper use (Fig. 8-22). Proper fit includes positioning with the crutches on inches in front and two inches lateral to the patient. The crutch height should be adjusted so greater than three finger widths from the axilla (Fig. 8-23). The handgrip height should be adjusted to the ulnar styloid process and allow for 20-25 degrees of elbow flexion while grasping the handgrip (Fig. 8-24). A padding attachment can be added with the device. Auxiliary crutches can be used with two-point, three-point, four-point, swing-by, and swing-through gait patterns.

**Fig. 8-21** A standard walker.

**Fig. 8-22** Auxiliary crutches.

**Fig. 8-23** A therapist assesses crutch height by determining the distance from the top of the crutch to the base of the axilla.

**Fig. 8-24** The therapist assesses crutch height by determining the distance from the top of the crutch to the base of the axilla.

SCOREBUILDERS

746 Unit 2 | Academic Review

### Central Nervous System

**Brain**

**Forebrain (Prosencephalon)<sup>109</sup>**

**Telencephalon**

The telencephalon is the largest division of the human brain and consists of the cerebral cortex, hippocampus, basal ganglia, and amygdala (Fig. 5-1).

**Cerebellum**

The cerebellum, which encompasses the major portion of the brain, is divided into the right and left cerebral hemispheres (Fig. 5-2). The two hemispheres are joined at the bottom by white matter, termed corpus callosum, which may differentiate from one side to the other. The surface of the cerebellum contains billions of neurons and glia that form the cerebral cortex. The outer surface of the cerebellum is termed gray matter and the interior is termed white matter. Sulci and fissures, which separate the lobes of the brain, each have a responsible for different functions.

**Stem**

The stem, which encompasses the major portion of the brain, is divided into the right and left cerebral hemispheres (Fig. 5-2). The two hemispheres are joined at the bottom by white matter, termed corpus callosum, which may differentiate from one side to the other. The surface of the cerebellum contains billions of neurons and glia that form the cerebral cortex. The outer surface of the cerebellum is termed gray matter and the interior is termed white matter. Sulci and fissures, which separate the lobes of the brain, each have a responsible for different functions.

**Fig. 5-1** A sagittal view of the human brain.

**Hemisphere Specialization/Dominance<sup>110</sup>**

**Left**

- Language
- Sequence and perform movements
- Understood language
- Produce written and spoken language
- Analytical
- Calculated
- Logical
- Rational
- Mathematical calculations
- Express positive emotions such as love and happiness
- Process verbally coded information as organized, logical, and sequential manner

**Right**

- Nonverbal processing
- Process information in a holistic manner
- Artistic abilities
- General concept comprehension
- Imbalanced mood
- Spatial relationships
- Kinesthetic awareness
- Unbalanced mood
- Understood nonverbal communication
- Mathematical reasoning
- Express negative emotions
- Body image awareness

**Fig. 5-2** The two hemispheres of the brain and the corresponding characteristics of each.

SCOREBUILDERS

Cardiovascular and Pulmonary Systems CHAPTER 6 443

**Obstruction can be classified as:**

- 100% → possible normal vessel
- 70-90% → mild obstruction
- 60-70% → moderate obstruction
- 50-60% → moderate to severe obstruction
- 50% → severe obstruction

**Interpretation**

SpO<sub>2</sub> is only an estimate of the arterial O<sub>2</sub> saturation; actual arterial oxygen saturation is +4% of SpO<sub>2</sub>. A number of factors limit the accuracy of pulse oximetry:

- Motion artifact
- Altered hemoglobin
- Hemocrit level
- Exposure of probe to ambient light during measurement
- Poor perfusion of the measurement site due to hypotension, hypothermia, low cardiac output or vasoconstrictor medications
- Nail preparation
- Nail polish or nail coverings (with finger probe)

**Rate Pressure Product (RPP)<sup>111</sup>**

RPP or double-product, is an index of myocardial oxygen consumption and coronary blood flow. RPP provides an easy to calculate prognostic estimate for the level of angina (stable) or the development of ECG abnormalities in patients with heart disease. The signs and symptoms of myocardial ischemia generally occur at an RPP of 2000-2500.

**Pulse Oximetry<sup>112</sup>**

A pulse oximeter estimates the percent of arterial oxygen saturation of hemoglobin by placing a sensor on the finger or earlobe (Fig. 6-22). The sensor measures the differential absorption of light by oxygenated and nonoxygenated hemoglobin. This estimate is displayed as SpO<sub>2</sub>, which is an indication of the partial pressure of oxygen in arterial blood.

**Procedures**

- Apply the sensor to the earlobe or fingertip.
- Assess the strength of the waveform or pulse amplitude to ensure that the sensor is detecting adequate arterial blood flow.
- Holding the finger dependent and occluding and covering the finger sensor to exclude ambient light improves the quality of oxygen in arterial blood.

**Fig. 6-22** A pulse oximeter.

SCOREBUILDERS

Safety and Protection; Professional Responsibilities; Research CHAPTER 9 799

**Lifting Guidelines<sup>113</sup>**

- Always attempt to increase your base of support
- Maintain a proper lumbar curve as you lift
- Push your feet when lifting; do not rest your back to turn
- Maintain a slow and controlled speed while lifting
- Only lift weight as a last resort

**Half-Kneeling Lift (Figs. 9-11, 9-14, 9-15, 9-16)**

1. Begin in a half-kneel position
2. The bottom leg should be positioned behind and to the side of the object
3. Maintain a normal lumbar lordosis
4. Lift the object into the knee and draw it closer to the trunk
5. Contract the lift to holding the object close as you assume a standing position

**One Leg Stance Lift**

1. Use a lifting lift object that can be lifted with one extremity
2. Face the object in a lunge position
3. Shift weight onto the forward extremity
4. Lift the object into the knee and draw it to match the object
5. The feet are then lift off the ground to maintain the shift in weight
6. Maintain a neutral spine throughout the lift

**Fig. 9-10** A patient begins a deep squat lift with the legs before the box.

**Fig. 9-11** The patient lifts the container while maintaining the back in a vertical position.

**Fig. 9-12** The patient completes the lift by achieving a fully erect posture.

**Fig. 9-13** The patient begins a half-kneeling lift while grasping the box in a half-kneeling position.

**Fig. 9-14** The patient lifts the box onto the knee while maintaining normal lordosis.

**Fig. 9-15** The patient gradually assumes a standing position.

**Fig. 9-16** The patient completes the lift by achieving a fully erect posture.

SCOREBUILDERS

302 Unit 2 | Academic Review

### Sensory Stimulation Techniques

**Facilitation**

- Approximation (Fig. 5-3)
- Joint compression
- Tapping
- Light touch
- Quick stretch
- Resistance
- Repeating
- Section

**Inhibition**

- Deep pressure
- Prolonged stretch
- Hugs
- Prolonged touch

**Fig. 5-31** The therapist is providing approximation to the legs while the patient is in standing in order to improve co-contraction around the feet and subsequent stability.

**PNF Diagonal Patterns – Upper Extremity**

PNF Diagonal Pattern	Shoulder Initial Position	Verbal Command	Shoulder End Position
<b>D1 Flexion (Figs. 5-32)</b>	Extension, abduction, medial rotation	Close your hand and pull up and across your body	Flexion, adduction, lateral rotation
<b>D1 Extension</b>	Flexion, adduction, lateral rotation	Open your hand and pull down and away from your body	Extension, abduction, medial rotation
<b>D2 Flexion</b>	Extension, adduction, medial rotation	Open your hand and pull up and away from your body	Flexion, abduction, lateral rotation
<b>D2 Extension</b>	Flexion, abduction, lateral rotation	Close your hand and pull down and across your body	Extension, adduction, medial rotation

**Fig. 5-32** D1P pattern of the upper extremity.

**Fig. 5-33** D2P pattern of the lower extremity.

SCOREBUILDERS

56 Unit 2 | Academic Review

### Upper Extremity (continued)

**Shoulder Joint (continued)**

Horizontal Abduction	Horizontal Adduction	Laternal Rotation	Medial Rotation
• Posterior deltoid	• Anterior deltoid	• Teres minor	• Subscapularis
• Infraspinatus	• Pectoralis major	• Infraspinatus	• Teres major
• Teres major		• Posterior deltoid	• Latissimus dorsi

**Elbow Joint**

Flexion	Extension	Supination	Pronation
• Biceps brachii	• Triceps brachii	• Biceps brachii	• Pronator teres
• Brachialis	• Anconeus	• Supinator	• Pronator quadratus
• Brachioradialis			

**Wrist Joint**

Flexion	Extension	Radial Deviation	Ulnar Deviation
• Flexor carpi radialis	• Extensor carpi radialis longus	• Extensor carpi radialis longus and brevis	• Extensor carpi ulnaris
• Flexor carpi ulnaris	• Extensor carpi radialis brevis	• Flexor carpi radialis	• Flexor carpi ulnaris
• Palmaris longus	• Extensor carpi ulnaris	• Extensor pollicis longus and brevis	

**Finger Joints**

Flexion	Extension	Abduction	Adduction
• Flexor digitorum profundus and superficialis	• Extensor digitorum (common)	• Abductor digiti minimi (5th digit)	• Palmar interossei
• Flexor digiti minimi (5th digit)	• Extensor indicis (second digit)		
• Interossei	• Extensor digiti minimi (5th digit)		
• Lumbricals			

**Thumb Joint**

Flexion	Extension	Abduction	Adduction	Opposition
• Flexor pollicis longus and brevis	• Extensor pollicis longus and brevis	• Abductor pollicis longus and brevis	• Adductor pollicis	• Opponens pollicis
• Opponens pollicis	• Abductor pollicis longus			• Flexor pollicis longus
				• Adductor pollicis brevis
				• Opponens digiti minimi

SCOREBUILDERS

Other Systems CHAPTER 7 673

### Other Systems Proficiencies

**1. Integumentary Anatomy**

Select the appropriate term for each of the specified locations. Answers must be selected from the Word Bank and can be used only once.

**Word Bank:** adipose tissue, arrector pili muscle, blood supply, dermis, epidermis, hair follicle, nerve, nerve ending, sebaceous gland, subcutaneous fatty tissue, sweat duct, sweat gland

**Fig. 6-23A** Apical segments right and left upper lobes. The patient is seated in a sitting position, leaning back 30-45 degrees. Percussion and vibration are performed above the clavicles.

**Fig. 6-23B** Posterior segment right upper lobe. The patient is seated in a sitting position, leaning back 30-45 degrees. Percussion and vibration are performed above the clavicles.

**Fig. 6-23C** Posterior segment left upper lobe. The patient is seated in a sitting position, leaning back 30-45 degrees. Percussion and vibration are performed above the clavicles.

**Fig. 6-23D** Anterior segment right and left upper lobes. The patient is in a sitting position, leaning back 30-45 degrees. Percussion and vibration are performed above the clavicles.

**Fig. 6-23E** Anterior segment right and left upper lobes. The patient is in a sitting position, leaning back 30-45 degrees. Percussion and vibration are performed above the clavicles.

**Fig. 6-23F** Anterior segment right and left upper lobes. The patient is in a sitting position, leaning back 30-45 degrees. Percussion and vibration are performed above the clavicles.

**Fig. 6-23G** Anterior segment right and left upper lobes. The patient is in a sitting position, leaning back 30-45 degrees. Percussion and vibration are performed above the clavicles.

**Fig. 6-23H** Anterior segment right and left upper lobes. The patient is in a sitting position, leaning back 30-45 degrees. Percussion and vibration are performed above the clavicles.

**Fig. 6-23I** Anterior segment right and left upper lobes. The patient is in a sitting position, leaning back 30-45 degrees. Percussion and vibration are performed above the clavicles.

**Fig. 6-23J** Anterior segment right and left upper lobes. The patient is in a sitting position, leaning back 30-45 degrees. Percussion and vibration are performed above the clavicles.

**Fig. 6-23K** Anterior segment right and left upper lobes. The patient is in a sitting position, leaning back 30-45 degrees. Percussion and vibration are performed above the clavicles.

**Fig. 6-23L** Anterior segment right and left upper lobes. The patient is in a sitting position, leaning back 30-45 degrees. Percussion and vibration are performed above the clavicles.

**Fig. 6-23M** Anterior segment right and left upper lobes. The patient is in a sitting position, leaning back 30-45 degrees. Percussion and vibration are performed above the clavicles.

**Fig. 6-23N** Anterior segment right and left upper lobes. The patient is in a sitting position, leaning back 30-45 degrees. Percussion and vibration are performed above the clavicles.

**Fig. 6-23O** Anterior segment right and left upper lobes. The patient is in a sitting position, leaning back 30-45 degrees. Percussion and vibration are performed above the clavicles.

**Fig. 6-23P** Anterior segment right and left upper lobes. The patient is in a sitting position, leaning back 30-45 degrees. Percussion and vibration are performed above the clavicles.

**Fig. 6-23Q** Anterior segment right and left upper lobes. The patient is in a sitting position, leaning back 30-45 degrees. Percussion and vibration are performed above the clavicles.

**Fig. 6-23R** Anterior segment right and left upper lobes. The patient is in a sitting position, leaning back 30-45 degrees. Percussion and vibration are performed above the clavicles.

**Fig. 6-23S** Anterior segment right and left upper lobes. The patient is in a sitting position, leaning back 30-45 degrees. Percussion and vibration are performed above the clavicles.

**Fig. 6-23T** Anterior segment right and left upper lobes. The patient is in a sitting position, leaning back 30-45 degrees. Percussion and vibration are performed above the clavicles.

**Fig. 6-23U** Anterior segment right and left upper lobes. The patient is in a sitting position, leaning back 30-45 degrees. Percussion and vibration are performed above the clavicles.

**Fig. 6-23V** Anterior segment right and left upper lobes. The patient is in a sitting position, leaning back 30-45 degrees. Percussion and vibration are performed above the clavicles.

**Fig. 6-23W** Anterior segment right and left upper lobes. The patient is in a sitting position, leaning back 30-45 degrees. Percussion and vibration are performed above the clavicles.

**Fig. 6-23X** Anterior segment right and left upper lobes. The patient is in a sitting position, leaning back 30-45 degrees. Percussion and vibration are performed above the clavicles.

**Fig. 6-23Y** Anterior segment right and left upper lobes. The patient is in a sitting position, leaning back 30-45 degrees. Percussion and vibration are performed above the clavicles.

**Fig. 6-23Z** Anterior segment right and left upper lobes. The patient is in a sitting position, leaning back 30-45 degrees. Percussion and vibration are performed above the clavicles.

**Fig. 6-23AA** Anterior segment right and left upper lobes. The patient is in a sitting position, leaning back 30-45 degrees. Percussion and vibration are performed above the clavicles.

**Fig. 6-23AB** Anterior segment right and left upper lobes. The patient is in a sitting position, leaning back 30-45 degrees. Percussion and vibration are performed above the clavicles.

**Fig. 6-23AC** Anterior segment right and left upper lobes. The patient is in a sitting position, leaning back 30-45 degrees. Percussion and vibration are performed above the clavicles.

**Fig. 6-23AD** Anterior segment right and left upper lobes. The patient is in a sitting position, leaning back 30-45 degrees. Percussion and vibration are performed above the clavicles.

**Fig. 6-23AE** Anterior segment right and left upper lobes. The patient is in a sitting position, leaning back 30-45 degrees. Percussion and vibration are performed above the clavicles.

**Fig. 6-23AF** Anterior segment right and left upper lobes. The patient is in a sitting position, leaning back 30-45 degrees. Percussion and vibration are performed above the clavicles.

**Fig. 6-23AG** Anterior segment right and left upper lobes. The patient is in a sitting position, leaning back 30-45 degrees. Percussion and vibration are performed above the clavicles.

**Fig. 6-23AH** Anterior segment right and left upper lobes. The patient is in a sitting position, leaning back 30-45 degrees. Percussion and vibration are performed above the clavicles.

**Fig. 6-23AI** Anterior segment right and left upper lobes. The patient is in a sitting position, leaning back 30-45 degrees. Percussion and vibration are performed above the clavicles.

**Fig. 6-23AJ** Anterior segment right and left upper lobes. The patient is in a sitting position, leaning back 30-45 degrees. Percussion and vibration are performed above the clavicles.

**Fig. 6-23AK** Anterior segment right and left upper lobes. The patient is in a sitting position, leaning back 30-45 degrees. Percussion and vibration are performed above the clavicles.

**Fig. 6-23AL** Anterior segment right and left upper lobes. The patient is in a sitting position, leaning back 30-45 degrees. Percussion and vibration are performed above the clavicles.

**Fig. 6-23AM** Anterior segment right and left upper lobes. The patient is in a sitting position, leaning back 30-45 degrees. Percussion and vibration are performed above the clavicles.

**Fig. 6-23AN** Anterior segment right and left upper lobes. The patient is in a sitting position, leaning back 30-45 degrees. Percussion and vibration are performed above the clavicles.

**Fig. 6-23AO** Anterior segment right and left upper lobes. The patient is in a sitting position, leaning back 30-45 degrees. Percussion and vibration are performed above the clavicles.

**Fig. 6-23AP** Anterior segment right and left upper lobes. The patient is in a sitting position, leaning back 30-45 degrees. Percussion and vibration are performed above the clavicles.

**Fig. 6-23AQ** Anterior segment right and left upper lobes. The patient is in a sitting position, leaning back 30-45 degrees. Percussion and vibration are performed above the clavicles.

**Fig. 6-23AR** Anterior segment right and left upper lobes. The patient is in a sitting position, leaning back 30-45 degrees. Percussion and vibration are performed above the clavicles.

**Fig. 6-23AS** Anterior segment right and left upper lobes. The patient is in a sitting position, leaning back 30-45 degrees. Percussion and vibration are performed above the clavicles.

**Fig. 6-23AT** Anterior segment right and left upper lobes. The patient is in a sitting position, leaning back 30-45 degrees. Percussion and vibration are performed above the clavicles.

**Fig. 6-23AU** Anterior segment right and left upper lobes. The patient is in a sitting position, leaning back 30-45 degrees. Percussion and vibration are performed above the clavicles.

**Fig. 6-23AV** Anterior segment right and left upper lobes. The patient is in a sitting position, leaning back 30-45 degrees. Percussion and vibration are performed above the clavicles.

**Fig. 6-23AW** Anterior segment right and left upper lobes. The patient is in a sitting position, leaning back 30-45 degrees. Percussion and vibration are performed above the clavicles.

**Fig. 6-23AX** Anterior segment right and left upper lobes. The patient is in a sitting position, leaning back 30-45 degrees. Percussion and vibration are performed above the clavicles.

**Fig. 6-23AY** Anterior segment right and left upper lobes. The patient is in a sitting position, leaning back 30-45 degrees. Percussion and vibration are performed above the clavicles.

**Fig. 6-23AZ** Anterior segment right and left upper lobes. The patient is in a sitting position, leaning back 30-45 degrees. Percussion and vibration are performed above the clavicles.

**Fig. 6-23BA** Anterior segment right and left upper lobes. The patient is in a sitting position, leaning back 30-45 degrees. Percussion and vibration are performed above the clavicles.

**Fig. 6-23BB** Anterior segment right and left upper lobes. The patient is in a sitting position, leaning back 30-45 degrees. Percussion and vibration are performed above the clavicles.

**Fig. 6-23BC** Anterior segment right and left upper lobes. The patient is in a sitting position, leaning back 30-45 degrees. Percussion and vibration are performed above the clavicles.

**Fig. 6-23BD** Anterior segment right and left upper lobes. The patient is in a sitting position, leaning back 30-45 degrees. Percussion and vibration are performed above the clavicles.

**Fig. 6-23BE** Anterior segment right and left upper lobes. The patient is in a sitting position, leaning back 30-45 degrees. Percussion and vibration are performed above the clavicles.

**Fig. 6-23BF** Anterior segment right and left upper lobes. The patient is in a sitting position, leaning back 30-45 degrees. Percussion and vibration are performed above the clavicles.

**Fig. 6-23BG** Anterior segment right and left upper lobes. The patient is in a sitting position, leaning back 30-45 degrees. Percussion and vibration are performed above the clavicles.

**Fig. 6-23BH** Anterior segment right and left upper lobes. The patient is in a sitting position, leaning back 30-45 degrees. Percussion and vibration are performed above the clavicles.

**Fig. 6-23BI** Anterior segment right and left upper lobes. The patient is in a sitting position, leaning back 30-45 degrees. Percussion and vibration are performed above the clavicles.

**Fig. 6-23BJ** Anterior segment right and left upper lobes. The patient is in a sitting position, leaning back 30-45 degrees. Percussion and vibration are performed above the clavicles.

**Fig. 6-23BK** Anterior segment right and left upper lobes. The patient is in a sitting position, leaning back 30-45 degrees. Percussion and vibration are performed above the clavicles.

**Fig. 6-23BL** Anterior segment right and left upper lobes. The patient is in a sitting position, leaning back 30-45 degrees. Percussion and vibration are performed above the clavicles.

**Fig. 6-23BM** Anterior segment right and left upper lobes. The patient is in a sitting position, leaning back 30-45 degrees. Percussion and vibration are performed above the clavicles.

**Fig. 6-23BN** Anterior segment right and left upper lobes. The patient is in a sitting position, leaning back 30-45 degrees. Percussion and vibration are performed above the clavicles.

**Fig. 6-23BO** Anterior segment right and left upper lobes. The patient is in a sitting position, leaning back 30-45 degrees. Percussion and vibration are performed above the clavicles.

**Fig. 6-23BP** Anterior segment right and left upper lobes. The patient is in a sitting position, leaning back 30-45 degrees. Percussion and vibration are performed above the clavicles.

**Fig. 6-23BQ** Anterior segment right and left upper lobes. The patient is in a sitting position, leaning back 30-45 degrees. Percussion and vibration are performed above the clavicles.

**Fig. 6-23BR** Anterior segment right and left upper lobes. The patient is in a sitting position, leaning back 30-45 degrees. Percussion and vibration are performed above the clavicles.

**Fig. 6-23BS** Anterior segment right and left upper lobes. The patient is in a sitting position, leaning back 30-45 degrees. Percussion and vibration are performed above the clavicles.

**Fig. 6-23BT** Anterior segment right and left upper lobes. The patient is in a sitting position, leaning back 30-45 degrees. Percussion and vibration are performed above the clavicles.

**Fig. 6-23BU** Anterior segment right and left upper lobes. The patient is in a sitting position, leaning back 30-45 degrees. Percussion and vibration are performed above the clavicles.

**Fig. 6-23BV** Anterior segment right and left upper lobes. The patient is in a sitting position, leaning back 30-45 degrees. Percussion and vibration are performed above the clavicles.

**Fig. 6-23BW** Anterior segment right and left upper lobes. The patient is in a sitting position, leaning back 30-45 degrees. Percussion and vibration are performed above the clavicles.

**Fig. 6-23BX** Anterior segment right and left upper lobes. The patient is in a sitting position, leaning back 30-45 degrees. Percussion and vibration are performed above the clavicles.

**Fig. 6-23BY** Anterior segment right and left upper lobes. The patient is in a sitting position, leaning back 30-45 degrees. Percussion and vibration are performed above the clavicles.

**Fig. 6-23BZ** Anterior segment right and left upper lobes. The patient is in a sitting position, leaning back 30-45 degrees. Percussion and vibration are performed above the clavicles.

**Fig. 6-23CA** Anterior segment right and left upper lobes. The patient is in a sitting position, leaning back 30-45 degrees. Percussion and vibration are performed above the clavicles.

**Fig. 6-23CB** Anterior segment right and left upper lobes. The patient is in a sitting position, leaning back 30-45 degrees. Percussion and vibration are performed above the clavicles.

**Fig. 6-23CC** Anterior segment right and left upper lobes. The patient is in a sitting position, leaning back 30-45 degrees. Percussion and vibration are performed above the clavicles.

**Fig. 6-23CD** Anterior segment right and left upper lobes. The patient is in a sitting position, leaning back 30-45 degrees. Percussion and vibration are performed above the clavicles.

**Fig. 6-23CE** Anterior segment right and left upper lobes. The patient is in a sitting position, leaning back 30-45 degrees. Percussion and vibration are performed above the clavicles.

**Fig. 6-23CF** Anterior segment right and left upper lobes. The patient is in a sitting position, leaning back 30-45 degrees. Percussion and vibration are performed above the clavicles.

**Fig. 6-23CG** Anterior segment right and left upper lobes. The patient is in a sitting position, leaning back 30-45 degrees. Percussion and vibration are performed above the clavicles.

**Fig. 6-23CH** Anterior segment right and left upper lobes. The patient is in a sitting position, leaning back 30-45 degrees. Percussion and vibration are performed above the clavicles.

**Fig. 6-23CI** Anterior segment right and left upper lobes. The patient is in a sitting position, leaning back 30-45 degrees. Percussion and vibration are performed above the clavicles.

**Fig. 6-23CJ** Anterior segment right and left upper lobes. The patient is in a sitting position, leaning back 30-45 degrees. Percussion and vibration are performed above the clavicles.

**Fig. 6-23CK** Anterior segment right and left upper lobes. The patient is in a sitting position, leaning back 30-45 degrees. Percussion and vibration are performed above the clavicles.

**Fig. 6-23CL** Anterior segment right and left upper lobes. The patient is in a sitting position, leaning back 30-45 degrees. Percussion and vibration are performed above the clavicles.

**Fig. 6-23CM** Anterior segment right and left upper lobes. The patient is in a sitting position, leaning back 30-45 degrees. Percussion and vibration are performed above the clavicles.

**Fig. 6-23CN** Anterior segment right and left upper lobes. The patient is in a sitting position, leaning back 30-45 degrees. Percussion and vibration are performed above the clavicles.

**Fig. 6-23CO** Anterior segment right and left upper lobes. The patient is in a sitting position, leaning back 30-45 degrees. Percussion and vibration are performed above the clavicles.

**Fig. 6-23CP** Anterior segment right and left upper lobes. The patient is in a sitting position, leaning back 30-45 degrees. Percussion and vibration are performed above the clavicles.

**Fig. 6-23CQ** Anterior segment right and left upper lobes. The patient is in a sitting position, leaning back 30-45 degrees. Percussion and vibration are performed above the clavicles.

**Fig. 6-23CR** Anterior segment right and left upper lobes. The patient is in a sitting position, leaning back 30-45 degrees. Percussion and vibration are performed above the clavicles.

**Fig. 6-23CS** Anterior segment right and left upper lobes. The patient is in a sitting position, leaning back 30-45 degrees. Percussion and vibration are performed above the clavicles.

**Fig. 6-23CT** Anterior segment right and left upper lobes. The patient is in a sitting position, leaning back 30-45 degrees. Percussion and vibration are performed above the clavicles.

**Fig. 6-23CU** Anterior segment right and left upper lobes. The patient is in a sitting position, leaning back 30-45 degrees. Percussion and vibration are performed above the clavicles.

**Fig. 6-23CV** Anterior segment right and left upper lobes. The patient is in a sitting position, leaning back 30-45 degrees. Percussion and vibration are performed above the clavicles.

**Fig. 6-23CW** Anterior segment right and left upper lobes. The patient is in a sitting position, leaning back 30-45 degrees. Percussion and vibration are performed above the clavicles.

**Fig. 6-23CX** Anterior segment right and left upper lobes. The patient is in a sitting position, leaning back 30-45 degrees. Percussion and vibration are performed above the clavicles.

**Fig. 6-23CY** Anterior segment right and left upper lobes. The patient is in a sitting position, leaning back 30-45 degrees. Percussion and vibration are performed above the clavicles.

**Fig. 6-23CZ** Anterior segment right and left upper lobes. The patient is in a sitting position, leaning back 30-45 degrees. Percussion and vibration are performed above the clavicles.

**Fig. 6-23DA** Anterior segment right and left upper lobes. The patient is in a sitting position, leaning back 30-45 degrees. Percussion and vibration are performed above the clavicles.

**Fig. 6-23DB** Anterior segment right and left upper lobes. The patient is in a sitting position, leaning back 30-45 degrees. Percussion and vibration are performed above the clavicles.

**Fig. 6-23DC** Anterior segment right and left upper lobes. The patient is in a sitting position, leaning back 30-45 degrees. Percussion and vibration are performed above the clavicles.

**Fig. 6-23DD** Anterior segment right and left upper lobes. The patient is in a sitting position, leaning back 30-45 degrees. Percussion and vibration are performed above the clavicles.

**Fig. 6-23DE** Anterior segment right and left upper lobes. The patient is in a sitting position, leaning back 30-45 degrees. Percussion and vibration are performed above the clavicles.

**Fig. 6-23DE** Anterior segment right and left upper lobes. The patient is in a sitting position, leaning back 30-45 degrees. Percussion and vibration are performed above the clavicles.

**Fig. 6-23DF** Anterior segment right and left upper lobes. The patient is in a sitting position, leaning back 30-45 degrees. Percussion and vibration are performed above the clavicles.

**Fig. 6-23DF** Anterior segment right and left upper lobes. The patient is in a sitting position, leaning back 30-45 degrees. Percussion and vibration are performed above the clavicles.

**Fig. 6-23DG** Anterior segment right and left upper lobes. The patient is in a sitting position, leaning back 30-45 degrees. Percussion and vibration are performed above the clavicles.

**Fig. 6-23DG** Anterior segment right and left upper lobes. The patient is in a sitting position, leaning back 30-45 degrees. Percussion and vibration are performed above the clavicles.

**Fig. 6-23DH** Anterior segment right and left upper lobes. The patient is in a sitting position, leaning back 30-45 degrees. Percussion and vibration are performed above the clavicles.

**Fig. 6-23DH** Anterior segment right and left upper lobes. The patient is in a sitting position, leaning back 30-45 degrees. Percussion and vibration are performed above the clavicles.

**Fig. 6-23DI** Anterior segment right and left upper lobes. The patient is in a sitting position, leaning back 30-45 degrees. Percussion and vibration are performed above the clavicles.

**Fig. 6-23DI** Anterior segment right and left upper lobes. The patient is in a sitting position, leaning back 30-45 degrees. Percussion and vibration are performed above the clavicles.

**Fig. 6-23DJ** Anterior segment right and left upper lobes. The patient is in a sitting position, leaning back 30-45 degrees. Percussion and vibration are performed above the clavicles.

**Fig. 6-23DJ** Anterior segment right and left upper lobes. The patient is in a sitting position, leaning back 30-45 degrees. Percussion and vibration are performed above the clavicles.

**Fig. 6-23DK** Anterior segment right and left upper lobes. The patient is in a sitting position, leaning back 30-45 degrees. Percussion and vibration are performed above the clavicles.

**Fig. 6-23DK** Anterior segment right and left upper lobes. The patient is in a sitting position, leaning back 30-45 degrees. Percussion and vibration are performed above the clavicles.

**Fig. 6-23DL** Anterior segment right and left upper lobes. The patient is in a sitting position, leaning back 30-45 degrees. Percussion and vibration are performed above the clavicles.

**Fig. 6-23DL** Anterior segment right and left upper lobes. The patient is in a sitting position, leaning back 30-45 degrees. Percussion and vibration are performed above the clavicles.

**Fig. 6-23DM** Anterior segment right and left upper lobes. The patient is in a sitting position, leaning back 30-45 degrees. Percussion and vibration are performed above the clavicles.

**Fig. 6-23DM** Anterior segment right and left upper lobes. The patient is in a sitting position, leaning back 30-45 degrees. Percussion and vibration are performed above the clavicles.

**Fig. 6-23DN** Anterior segment right and left upper lobes. The patient is in a sitting position, leaning back 30-



## SPOTLIGHT ON SAFETY



### SPOTLIGHT ON SAFETY CLINICAL RELEVANCE OF REFLEX TESTING<sup>28</sup>

**Deep tendon reflex (DTR)** testing can assist the therapist in determining the type of pathology that exists. Absent DTRs will indicate a lesion in the reflex arc itself. If absent reflexes accompany sensory loss in the distribution of the nerve that is supplying a particular reflex, the lesion is found within the afferent arc of the reflex and is located in either the nerve or dorsal horn. If an absent DTR accompanies paralysis, fasciculations or atrophy, the lesion is found within the efferent arc of the reflex and may include the efferent nerve, anterior horn cells or both.

**Peripheral neuropathy** is the most common etiology surrounding absent reflexes. Associated conditions can include diabetes, alcoholism, vitamin deficiencies such as pernicious anemia, certain cancers, and certain toxins (lead, arsenic, vincristine). Neuropathies will typically present with sensory, motor or mixed impairments and may affect all components of the reflex arc.

**Hyperactive DTRs** are found when there is interruption of the cortical supply to the lower motor neuron (secondary to upper motor neuron lesion). The interruption exists above the segment of the reflex arc, with other findings determining localization of the exact lesion. Assessment of the DTRs can provide information as to the level of lesion that exists within the central nervous system.

**Spotlight on Safety** provides students with critical safety information relevant to selected physical therapy topics.



## CONSIDER THIS



### CONSIDER THIS DOCUMENTATION OF RECORDED MEASURES<sup>3</sup>

Health care providers work in an integrated fashion to deliver patient care. The patient medical record is one of the primary ways that health care providers keep each other informed of current patient status and other relevant information. As a result, it is critical that health care providers document relevant information in the medical record in a timely and accurate manner. Failure to meet this standard potentially results in ineffective medical care and may jeopardize patient safety.

The results of goniometric measurements can be used to illustrate this point. Let's assume that a therapist reviews the medical record of a patient recovering from a motor vehicle accident, in which the patient sustained multiple lower extremity injuries. Upon reviewing the medical record, the therapist determines that in successive notes the patient's right knee range of motion was described as 10-105 degrees and 10-0-105 degrees.

Although the recorded measurements appear extremely similar, they are in fact very different. 10-105 degrees indicates that the patient's range of motion begins at 10 degrees of knee flexion and ends at 105 degrees of knee flexion (95 degrees of total available movement). Conversely, the use of "0" between the starting and ending values indicates the patient has 10 degrees of knee hyperextension and 105 degrees of knee flexion (115 degrees of total available movement).

**Consider This** offers students valuable information designed to increase flexibility with core academic content.



## PROFICIENCIES

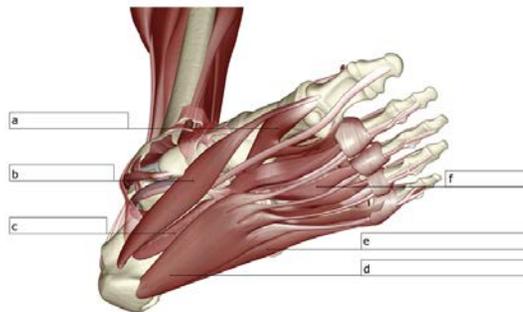


### Musculoskeletal System Proficiencies

#### 3. Musculoskeletal Lower Extremity Anatomy II

Identify the appropriate term for each of the specified locations. Answers must be selected from the Word Bank and can be used only once.

**Word Bank:** abductor digiti minimi, abductor hallucis, flexor digitorum brevis, flexor hallucis brevis, lumbricals, quadratus plantae



**Proficiencies** provide students with an opportunity to determine their competency in a variety of academic areas.



## CHAPTER ESSENTIALS



### Cardiovascular and Pulmonary Systems Essentials

- The components of the cardiac conduction system include the sinoatrial (SA) node, internodal tracts, atrioventricular (AV) node, common AV bundle or bundle of His, right and left bundle branches, and Purkinje fibers.
- Sympathetic nerves stimulate the heart to beat faster (chronotropic effect) and with greater force of contraction (inotropic effect). Parasympathetic nerves slow the heart rate (chronotropic effect) primarily through their influence on the SA node.
- The Valsalva maneuver produces increased intrathoracic pressure, increased central venous pressure, and decreased venous return and should be avoided, especially by patients with heart, blood vessel or lung disease.
- Pulmonary edema can be fatal if not treated. Seek immediate emergency medical assistance if the signs or symptoms of acute pulmonary edema develop including extreme shortness of breath or difficulty breathing, a feeling of suffocating or drowning, wheezing or gasping for breath, anxiety, restlessness or a sense of apprehension or a cough that produces frothy sputum tinged with blood.
- Arterial blood gases evaluate acid-base status (pH), ventilation (PaCO<sub>2</sub>), and oxygenation (PaO<sub>2</sub>). Mean arterial blood gas values in adults at sea level are: pH = 7.4; PaCO<sub>2</sub> = 40 mm Hg; PaO<sub>2</sub> = 97 mm Hg; HCO<sub>3</sub><sup>-</sup> = 24 mEq/L.
- A complete blood count (CBC) measures red blood cell count, total white blood cell count, white blood cell differential, platelets, hemoglobin, and hematocrit.

**Chapter Essentials** allow students to reinforce their mastery of critical academic content.



## CLINICAL PRACTICE GUIDELINES

NEW!



### CLINICAL PRACTICE GUIDELINES HIP OSTEOARTHRITIS

- SHOULD**
  - Flexibility, strengthening, and endurance exercises
  - Functional, gait, and balance training, including the proper use of assistive devices
  - Education on activity modification, exercise, body weight management, and methods of unloading arthritic joints
- MAY**
  - Manual therapy, including joint and soft tissue mobilizations
  - Aquatic exercise
  - Cryotherapy/thermotherapy
- AVOID**
  - Bracing
  - TENS or other forms of electrical stimulation

A **clinical practice guideline (CPG)** is a statement that aims to provide a framework for the optimal care of a patient. The guideline generally consists of a list of recommendations regarding the diagnosis, prognosis, interventions, and assessment of outcome for a specific medical condition.



## CLINICAL PREDICTION RULES

NEW!



### CLINICAL PREDICTION RULE SCREENING FOR KNEE FRACTURE: OTTAWA KNEE RULES

The Ottawa Knee Rules is an instrument used for patients with an acute blunt trauma to the knee in which a fracture may be suspected. If the patient meets the criteria within the instrument, they should be referred for radiographs to rule out a fracture.

#### Predictive Factors

1. Age is > 54 years old
2. Tenderness at the fibular head
3. Isolated tenderness of the patella without other bone tenderness
4. Inability to flex the knee 90 degrees
5. Inability to bear weight for four steps (both immediately and in the emergency department)

#### Scoring

If the patient meets any of the five criteria within the instrument, they should be referred for radiographs.

A **clinical prediction rule (CPR)** is a research-based tool that is intended to assist therapists in making clinical decisions. CPRs can be useful to therapists in their decision making process to help enhance patient outcomes.

Abdominal Pain Quadrant and Potential Etiologies<sup>17,20</sup>

Left upper quadrant	Right upper quadrant	Left lower quadrant	Right lower quadrant
Gastric ulcer	Hepatomegaly	Perforated colon	Kidney stone
Perforated colon	Duodenal ulcer	Ileitis	Ureteral stone
Pneumonia	Cholecystitis	Sigmoid diverticulitis	Meckel diverticulum
Spleen injury	Pneumonia	Kidney stone	Appendicitis
Spleen rupture	Hepatitis	Ureteral stone	Cholecystitis
Aortic aneurysm	Biliary stones	Intestinal obstruction	Intestinal obstruction

#### Gastrointestinal System Terminology

**Adhesion:** Fibrous bands of tissue that bind together normally separate anatomic structures.

**Anastomosis:** Joining of two ducts, blood vessels or bowel segments to allow flow from one to the other. An anastomosis may be naturally occurring or may be created during embryonic development, surgery or by pathologic means.

**Ascites:** Fluid in the peritoneal cavity, usually causing abdominal swelling.

**Barium:** A substance that, when swallowed or given rectally as an enema, makes the upper gastrointestinal tract visible on x-ray.

**Biopsy:** Removal of a sample of tissue taken from the body for study, usually under a microscope.

**Colectomy:** The surgical removal of part or all of the colon.

**Colonoscopy:** Visual inspection of the interior of the colon with a flexible, lighted instrument inserted through the rectum.

**Colostomy:** The surgical creation of an opening from the colon through the abdominal wall.

**Constipation:** Infrequent or difficult passage of stool, secondary to an increase in the hardness of the stool.

**Diarrhea:** Abnormal frequency or volume of stool that often appears as a symptom of certain gastrointestinal pathologies.

GOLD

Cerebral Palsy

#### DIAGNOSIS

##### What condition produces a patient's symptoms?

Cerebral palsy (CP) is an umbrella term used to describe a group of non-progressive movement disorders that result from brain damage. CP is the most common cause of permanent disability in children.

##### An injury was most likely sustained to which structure?

There is a wide variety of neurological damage that can occur with injury. Autopsy reports have indicated lesions that include hemorrhage below the lining of the ventricles, damage to the central nervous system that caused neuropathy and anoxia, and hypoxia that caused encephalopathy. Hypoxic and ischemic injuries disrupt normal metabolism that results in global damage to the developing fetus. CP is classified by neurological dysfunction and extremity involvement. Spastic CP involves upper motor neuron damage; athetoid CP involves damage to the basal ganglia.

##### What additional information should be obtained to confirm the diagnosis?

Diagnosis of CP is regularly confirmed through an extensive neurological evaluation, patient observation, and patient history including developmental progress, and the presence of pathological reflexes. Differential diagnosis is performed to rule out other potential disorders.

#### EXAMINATION

##### What history should be documented?

Important areas to explore include past medical history, risk factors, maternal course of pregnancy, medications, family history, current characteristics, social history, and social support system.

Informative academic information assists students to review and relearn critical NPTE-PT content.



Clinical application templates guide students through the patient/client management of commonly encountered medical diagnoses.



# Designed for Engaging Studying



Scorebuilders' products are known for their creative design and innovative features. Break free from traditional encyclopedic resources and feel the power of well conceived design.

ASSESSMENT	PERCENT OF EXAM QUESTIONS
Physical Therapy Examination (38-52)	34
Foundations for Evaluation, Differential Diagnosis, and Progress (13-40)	34.5
Interventions (47-56)	33.5
Equipment, Devices, and Technologies: Therapeutic Modalities (9-12)	3.5
Safety and Protection, Professional Responsibilities, Research (23-27)	4.5

**CONSIDER THIS**  
SCREENING OF SUPERFICIAL, DEEP, AND CORTICAL SENSATIONS<sup>10</sup>

When screening a patient's sensation, there are typical stimuli that produce an expected response that measures a patient's sensation as normal or impaired.

- **Barognostic**: perceives the weight of different objects in the hand
- **Deep pain**: squeezes the forearm or calf muscle
- **Graphoesthesia**: identify a number or letter drawn on the skin without visual input
- **Kinaesthesia**: identify direction and extent of movement of a joint or body part
- **Light touch**: perceive touch through light pressure or use of a cotton ball
- **Localization**: ability to identify the exact location of light touch on the body using a verbal response or gesturing
- **Proprioception**: identify a stable position of an extremity or body part
- **Stereognosis**: identify an object without sight (Fig. 5-24)
- **Superficial pain**: perceive nociceptive stimulus using a pin cap, paper clip end or pin
- **Temperature**: perceive warm and cold tubes
- **Two-point discrimination**: using a two-point caliper on the skin, identify one or two points without visual input (Fig. 5-25)
- **Vibration**: perceive vibration or pain through a tuning fork

Equipment found with any of the above sensation may designate lesion or pathology to a particular pathway or region of the brain. The therapist can utilize this information to enhance understanding of the neurological impairment as well as to customize the plan of care.

**Fig. 5-24** The patient is trying to identify the paper clip without visual feedback and using only the sense of touch. This is an examination of stereognosis.

**Fig. 5-25** Examination of two-point discrimination.

Tables, charts, graphics, and text allow students to quickly assimilate essential academic content.

Our innovative design allows study sessions to be more productive and enjoyable.

**Fig. 8-86** A therapist tips a wheelchair backward.

**Fig. 8-87** The wheelchair is moved forward until the rear wheels come in contact with the curb.

**Fig. 8-88** The casters are lowered and the rear wheels are rolled around the curb.

**Fig. 8-89** The rear wheels and casters are positioned on the elevated surface.

**Wheelchair Mobility<sup>11</sup>**

**Ascending a curb with a forward approach**

1. Incline the front casters of the wheelchair by tipping the wheelchair backward (Fig. 8-86).
2. Move the wheelchair forward until the rear wheels are in contact with the curb and the casters are above the curb (Fig. 8-87).
3. Lower the casters on the elevated surface and ascend the curb with the rear wheels until the rear wheels and the casters are in contact with the elevated surface (Figs. 8-88 & 8-89).

**Ascending a curb with a backward approach**

1. Position the patient facing away from the curb.
2. Standing on the upper surface, lift and roll the rear wheels backward up the curb.
3. Continue to roll the wheelchair backward until the casters are in contact with the upper surface.

**Descending a curb with a forward approach**

1. Position the casters close to the elevated edge of the curb.
2. Tip the wheelchair backward and slowly roll the wheelchair forward (the rear wheels are in contact with the lower surface).
3. Gently lower the casters to the lower surface.

**Descending a curb with a backward approach**

1. Position the patient facing away from the curb.
2. Move the wheelbar backward and slowly lower the rear wheels to the lower surface maintaining contact with the curb.
3. Continue to roll the wheelchair backward and gently lower the casters to the lower surface.

# Test Drive the NPTE-PT

**PTEXAM: The Complete Study Guide** includes three full-length sample examinations (540 questions) delivered through our eLearning site, **Insight**.

## ► PTEXAM THREE: QUESTION 160

A physical therapist treats an infant diagnosed with torticollis with marked lateral flexion of the neck to the right. As part of the infant's plan of care the therapist performs passive stretching activities to improve the patient's range of motion. The **MOST** appropriate stretch for the patient is:

1. lateral flexion to the right and rotation to the right
2. lateral flexion to the left and rotation to the left
3. lateral flexion to the right and rotation to the left
4. lateral flexion to the left and rotation to the right

### Question

Our questions are designed to replicate the style, format, and difficulty level of the questions on the NPTE-PT. The questions are located within our eLearning site Insight.

Torticollis is characterized by lateral flexion of the head toward the affected side and rotation toward the unaffected side. The condition is caused by a contracture of the sternocleidomastoid muscle.

1. Stretching in lateral flexion to the right would be inappropriate since the question indicates that the patient presents with marked lateral flexion of the neck to the right. The direction of the stretch for the rotation component is accurate.
2. Stretching in lateral flexion to the left would be beneficial, however, patients with torticollis present with rotation to the opposite side. As a result, the rotation component should be stretched to the right and not the left.
3. This option more accurately characterizes the clinical presentation of the patient than it does the necessary stretch. The question indicates that the patient presents with marked lateral flexion of the neck to the right and therefore it would not make sense to stretch to the right. The direction of stretch for the rotation component is also inaccurate.
4. **Stretching the patient in lateral flexion to the left and rotation to the right is the correct answer since it is opposite of the patient's current contracture (i.e., marked lateral flexion of the neck to the right and rotation to the left).**

### General Statement

This section introduces relevant subject matter and offers related value added information.

### Explanation of the Correct and Incorrect Options

The explanations offer incredibly detailed information supporting why the correct answer is correct and why each incorrect answer is incorrect.

Correct Answer: 4 (Palisano p. 184)



### Correct Answer and Resource

This section provides the correct answer and the author name and page number that substantiates the correct answer. A bibliography provides complete information on each resource including the edition used.

### Video Explanation

Video explanations provide candidates with the opportunity to watch videos that compare and contrast good, better, and best options for select examination questions.



## Gold Standard

Our explanation of answers enhance student decision making when choosing between good, better, and best options.

Additional features such as test taking tips, level analysis, and academic focus areas help students to remediate identified academic deficiencies.

**System: Musculoskeletal System**  
**Content Outline: Interventions**

### System and Content Outline Assignment

This section assigns a system and content outline category to each question allowing candidates to assess examination performance in unique areas.



**p. 123, 186-187**

### Academic Focus Area

This feature immediately directs the user to critical pieces in the academic review section related to the particular subject matter.



**Test Taking Tip:** It is possible for a candidate to eliminate two of the presented options without having any specific knowledge related to torticollis. The question indicates that the patient presents with marked lateral flexion of the neck to the right. Based on that particular clinical finding it becomes apparent that the stretch would need to be in the opposite direction (i.e., to the left). Often when presented with information that is unfamiliar, candidates fail to recognize that they can still narrow down the presented options. It is critically important for candidates to use this valuable skill since it can significantly increase the probability of identifying the correct response.

### Test Taking Tip

This section offers unique Test Taking Tips, when possible, to assist candidates to use deductive reasoning strategies when academic knowledge alone is not adequate to correctly answer a question.



## Gold Standard

Scorebuilders' questions are thought-provoking, challenging questions designed to be consistent with the specifications and rigor of the NPTE-PT blueprint.



**Level 1**

### Level Analysis

This feature allows candidates to analyze their examination performance according to three different levels of questions.

**Level 1** - Questions require candidates to possess basic foundational academic knowledge.

**Level 2** - Questions require candidates to integrate numerous pieces of information or to apply knowledge in a given clinical scenario.

**Level 3** - Questions require candidates to systematically analyze and often interpret information to determine an appropriate course of action. The questions tend to have some degree of subjectivity and candidates are required to assign varying degrees of importance to different variables.



# A Technology Monster



Students purchasing our review book receive a unique registration code for our online eLearning site called **Insight**. This site offers students a state of the art testing platform with a sophisticated performance analysis section. Students have the ability to create custom exams and compare their results to other students in a variety of system and content outline areas.

After taking each of the examinations in Insight, candidates utilize the sophisticated performance analysis features to assess their examination performance. A brief description of some of the more prominent performance analysis features is presented.



## Gold Standard

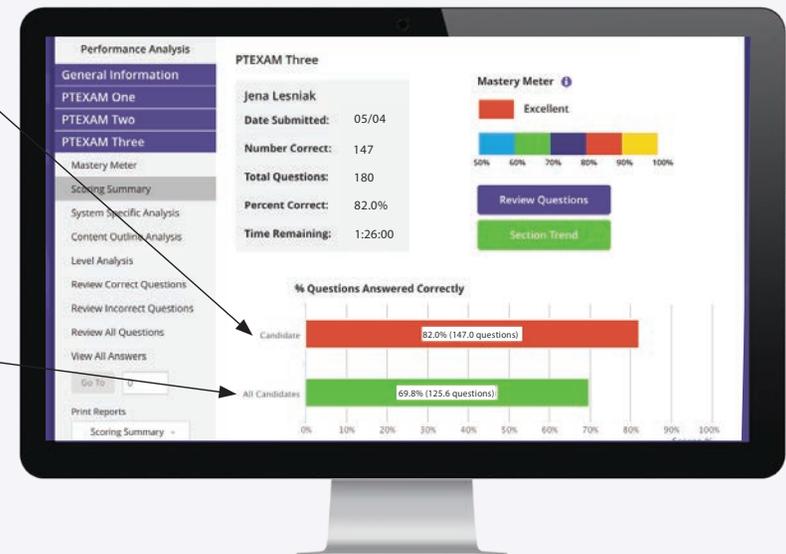
Scorebuilders has made a massive investment in technology and uses this competitive advantage to provide students with the most realistic testing experience possible. Continuous innovation and commitment to technology widens the gap between Scorebuilders and all other licensing companies.

### Candidate Score

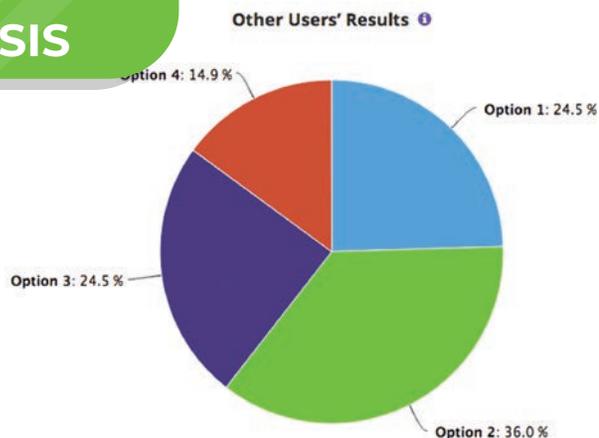
A candidate's score reflects the number of questions answered correctly for a given examination.

### Mean Score

The mean score allows candidates to compare their score to the average score of thousands of other candidates taking the same examination. The mean score accounts for the relative difficulty of the examination and is a critical piece of data for candidates when assessing examination performance.



## ITEM ANALYSIS

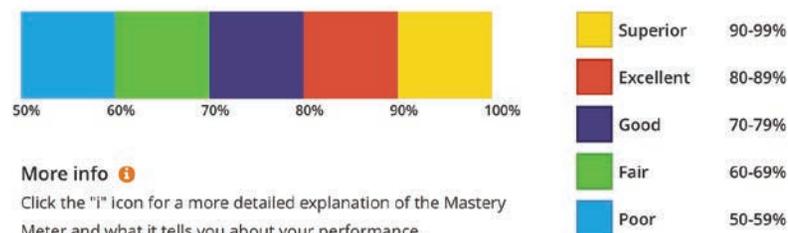


The **item analysis** feature allows candidates to identify the percentage of candidates answering the question correctly and the specific percentages of candidates selecting each of the four options. Candidates can utilize this information to critically evaluate their approach to answering questions and improve future decision making.

## MASTERY METER

### Mastery Meter

What do all those colors mean?



### More info

Click the "i" icon for a more detailed explanation of the Mastery Meter and what it tells you about your performance.

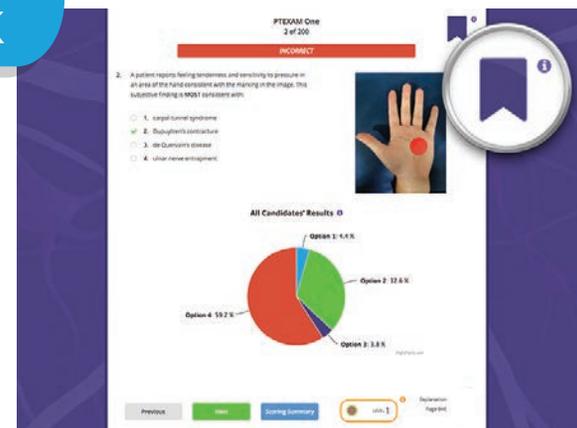
The **Mastery Meter** assigns candidates a level of mastery in each category based on the percentage of questions answered correctly. Candidates should strive to achieve a score of "Superior" or "Excellent" on the Mastery Meter in each category.

## SYSTEM AND CONTENT OUTLINE ANALYSES

	Number Correct	Total Questions	% Correct	Mastery Meter		
Musculoskeletal System	23	39	60%	Fair	i	Details
Neuromuscular and Nervous Systems	26	33	80%	Excellent	i	Details
Cardiovascular/Pulmonary and Lymphatic Systems	14	25	55%	Poor	i	Details
Other Systems	20	22	90%	Superior	i	Details
Non-Systems	22	31	70%	Good	i	Details

The **system and content outline analyses** offer candidates an immediate analysis of their performance in specific areas of the NPTE-PT. Candidates can click on a given area and immediately review their performance in relation to the mean score of other users. They also have the ability to selectively review questions only within specific system and content outline areas.

## STUDY STACK



Our **Study Stack** feature allows candidates to tag specific questions that they would like to review at a later time. Candidates can easily add or remove questions from their Study Stack by simply clicking the bookmark icon. Review a created Study Stack in its entirety or by System area. Customization of remedial activities is a great way to boost examination scores!

# Jump Start your Academic Review



## Edition Guarantee!

We have always believed that sleep is overrated! As soon as we release a new edition of **PTEXAM: The Complete Study Guide**, we immediately get to work on creating the next edition. Our eLearning site **Insight** includes an Edition Guarantee which delivers periodic updates to existing users of the current edition.

## Basecamp - Start Climbing!

We created an innovative learning tool, **Basecamp**, that provides students with an incredibly efficient complementary product to review academic content within **PTEXAM: The Complete Study Guide**. The content is organized in five distinct Mountains (Musculoskeletal, Neuromuscular, Cardiopulmonary, Other Systems, and Non-Systems) and 140 Trails. Each trail has dedicated assignments, flash cards, videos, and exams. Collectively, **Basecamp** includes 6,000 content-driven questions. A \$25 off coupon for **Basecamp** is included within **Insight**.



# Class Orders and Volume Discounts

Take advantage of the opportunity to secure the most comprehensive review book available for the NPTE-PT at savings of up to 20%. In addition, class orders include free shipping and handling within the continental United States.

1



## INFORM THE MASSES

Share the product and discount information with your class. Let them know that by ordering as a class they can save big money and take an important step toward achieving their licensing goals.

2



## RALLY THE TROOPS

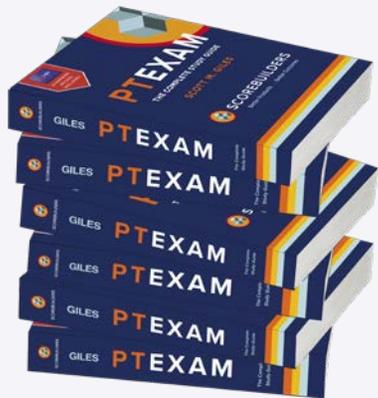
Establish a deadline for all orders to be submitted to the student organizer. Send a friendly reminder or two along the way since we are all human!

3



## SUBMIT YOUR ORDER

Compile the submitted orders and payment information and select your preferred method of ordering. Get excited to receive the best licensing products on this planet!



Quantity	Savings per book
10-19	10% (\$89.10)
20+	20% (\$79.20)

**Organize Your Order Today!**

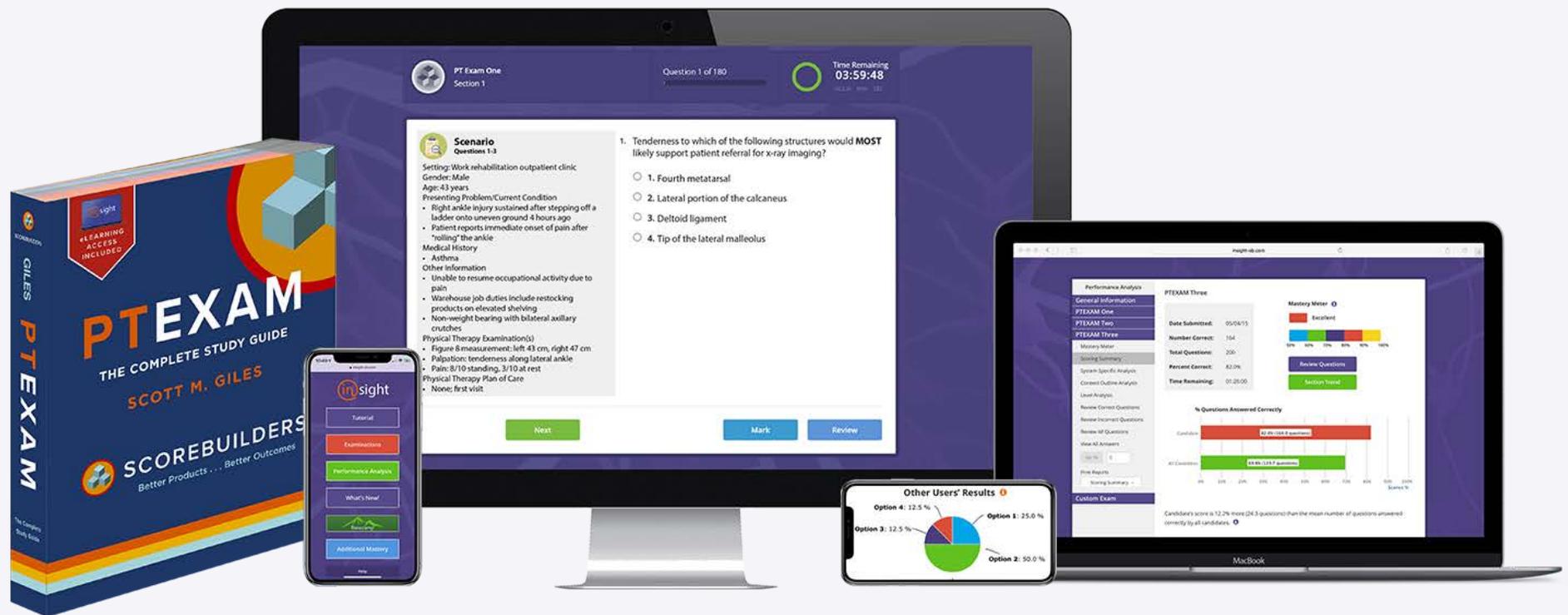
**PLUS:** Students organizing a group order of 20+ products are eligible to earn a **FREE** product of their choice!



# Better Products...Better Outcomes!

If you are a faculty member and considering adopting **PTEXAM: The Complete Study Guide** into your curriculum, send us an email at [info@scorebuilders.com](mailto:info@scorebuilders.com) or contact us by phone (207)885-0304.

If you are a student interested in placing a group order, you can download an order form on our website [www.scorebuilders.com](http://www.scorebuilders.com) on the Offers page.



**SCOREBUILDERS**  
Better Products...Better Outcomes