



I-TESTS GUIDE

A guide to the on-line examination process

NAIOMT offers the following INTERNET TESTS (I-tests) on-line:

I-test 500 - Level I

I-test 600 - Level II Upper Quadrant

I-test 610 - Level II Lower Quadrant

Completion of all three I-tests will be the equivalent of the current Level II written (paper) examination.

For **general information** about the tests, please go to the following documents at www.naiomt.com - exams

- Information online exams — information and Q & A
- Schedule of exam dates
- Registration on-line

Format of each I-test

- 100 questions in multiple choice, true-false or matching formats
- Test arranged in 20 knowledge groups, five question from each group
- Questions will be presently randomly, and there is opportunity to revisit questions
- There is no penalty for questions omitted or answered incorrectly
- Pass mark is 70%
- Maximum test-time is 2 hours
- Proctored, closed-book test
- Some null questions are used (i.e which of the following would rule out the..)

Scope of each test

- The scope of the test will be the material covered in the course of the same number (i.e. I-test 500 covers material from level I/500 course)
- Each I-test will examine your knowledge of the material from one 6-day course syllabus (i.e. 42 hours of a Level I/500 core course). The scope of the I-test will be the application and clinical reasoning of the material taught in the class, the content of the course manual and independent study from the course reading list.
- Thoracic content will be basic and tested in I-tests 500 and 600. I-test 500 Level I will include questions relevant to the thoracic scan as taught in that class. I-test 600 -Level II Upper Quadrant will include basic thoracic applied anatomy, biomechanics and pathology questions and application to assessment and treatment.

I-test 500 - Level I

100 questions — 20 groups — 2 hours

GR	GROUP NAME	DESCRIPTION OF TYPICAL CONTENT AREAS
1	Dermatomes	Dermatomal origin of upper and lower quadrant skin areas C1-T6; T7-S4
2	Peripheral cutaneous nerves	Match area of skin with name of cutaneous nerve, upper and lower quadrants
3	Key muscles (“myotomes”)	Match key muscle (“myotome”) muscle function or named muscle, with the spinal nerve root number
4	Peripheral nerve muscle supply	Match the named muscle with its peripheral nerve supply, upper and lower quadrant
5	Tendon reflexes	Match named muscle tendon with the spinal nerve root
6	Neurological or vascular compromise	Recognition of signs & symptoms of neurological compromise: cervical, thoraco-lumbar, cauda equina or major vascular compromise
7	Classification of pain	Medical screening & classification of pain per MacNab’s classification (vascular, visceral, neurogenic, spondylogenic etc.)
8	Pain modulation and nociceptors	Gate control and location of nociceptors & original theories on pain modulation and effects of application of manual and adjunct treatments
9	Scan: observation	Scanning exam: interpretation of observation. Seriousness of the observation finding of: skin changes and scars, muscle or bony asymmetry, postural abnormalities, swelling, etc.
10	Scan: STT spine	Scanning exam: interpretation of results of spinal selective tissue tension – potential relation to medical pathology and common spinal conditions or movement dysfunctions
11	Scan: lumbar spine general stress tests	Scanning exam: interpretation of results of lumbar spine and pelvis general stress or provocative tests — compression, torsion, shear and traction tests
12	Scan: cervical & thoracic spine general stress tests	Scanning exam: interpretation of results of cervical and thoracic spine general stress or provocative tests. Compression or traction in combined diagonal motions and non-neutral positions
13	Neurological mobility tests	Dural and neuro-meningeal mobility tests
14	Neurological testing of motor function	Method of testing, joint position, principles of differentiation from other muscle dysfunctions
15	Neurological testing of sensory function	Method of testing, principles of differentiation of nerve palsy from peripheral nerve and CNS disorder
16	Differential diagnosis	Basic clinical reasoning and application of selective tissue tension from the neurological examination
17	Peripheral joint STT	Basic principles of interpretation with emphasis on selective tissue tension of extremity joints
18	Capsular patterns of restriction	Capsular patterns – especially of the extremity joints
19	Treatment of extremities	Stages of healing and indication/contraindications to DTF, external orthoses, exercise etc.
20	Treatment of spine	Indications & contra-indications to traction, ergonomics and basic spinal exercise and spinal position for treatment including red flags and VBI

I-test 600 - Level II Upper Quadrant

100 questions — 20 groups — 2 hours

GR	GROUP NAME	DESCRIPTION OF TYPICAL CONTENT AREAS
1	Scan: observation	Cervical and thoracic scanning exams: interpretation and relevance of observation findings of skin changes and scars, muscle/bony asymmetry, postural abnormalities, and swelling
2	Scan: STT spine	Cervical and thoracic scanning exams: interpretation of results of spinal selective tissue tension and potential relation to medical pathology and common spinal conditions.
3	Scan: cervical & thoracic spine general stress tests	Interpretation of results of cervical and thoracic spine general stress or provocative tests in the scanning exam – compression or traction in combined diagonal positions
4	Neurological mobility tests	Dural and neuro-meningeal mobility tests
5	Neurological testing of motor function	Principles of muscle testing and differentiation from other muscle dysfunctions
6	Neurological testing of sensory function	Methods of testing and principles of differentiation of nerve palsy from peripheral nerve and CNS disorders
7	Differential diagnosis from spinal scanning exam	Cervical and thoracic scanning examination clinical reasoning, with emphasis on muscle and neurologic tests
8	Differential diagnosis from upper extremity joint scans	Principles of interpretation of scanning examination findings with emphasis on selective tissue tension of upper quadrant extremity joints
9	Capsular patterns of restriction	Capsular patterns of restriction, especially of upper limb extremity joints
10	Signs & symptoms of serious pathology	Recognition of signs & symptoms of cervical or thoracic neurological compromise or major vascular compromise
11	Indications and contraindications to OMPT	Indications and contraindications to OMPT intervention including suspicion of non-musculoskeletal origin of pain and MacNab's classification of pain (viscerogenic, vasculogenic etc)
12	Cervical and thoracic anatomy and biomechanics	Cervical and thoracic spine anatomy and biomechanics
13	Pathology of the cervical and thoracic region	Pathology and movement dysfunctions of the cervical and upper thoracic region
14	Cervical and thoracic spine clinical reasoning and OMPT treatment	Cervical and thoracic spine clinical reasoning, assessment and selection of manual physical therapy interventions/ treatments
15	Biomechanics theories	Definitions and applied theory of osteokinematics, arthrokinematics, myokinematics and basic kinetics
16	Shoulder girdle anatomy and biomechanics	Shoulder girdle anatomy and biomechanics (gleno-humeral, sternoclavicular, acromio-clavicular and scapulo-thoracic)
17	Elbow region anatomy and biomechanics	Elbow region anatomy and biomechanics (elbow and superior radio-ulnar)
18	Wrist and hand anatomy and biomechanics	Wrist and hand anatomy and biomechanics (inferior radio-ulnar, wrist and hand)
19	Upper extremity pathology	Upper extremity pathology and movement dysfunctions
20	Upper extremity clinical reasoning and OMPT treatment	Upper extremity clinical reasoning, assessment and selection of manual physical therapy interventions/ treatments including grading of techniques

I-test 610 - Level II Lower Quadrant**100 questions — 20 groups — maximum 2 hours**

GR	GROUP NAME	DESCRIPTION OF TYPICAL CONTENT AREAS
1	Scan: observation	Lumbo-sacral scanning exam: interpretation and relevance of the observation findings of skin changes and scars, muscle or bony asymmetry, postural abnormalities and swelling
2	Scan: STT spine	Lumbo-sacral scanning exam: interpretation of results of spinal selective tissue tension. Potential relation to medical pathology and common spinal conditions.
3	Scan: lumbo-sacral spine general stress tests	Interpretation of results of lumbo-sacral general stress or provocative tests in scanning examination - compression, torsion, shear and traction tests
4	Neurological mobility tests	Dural and neuro-meningeal mobility tests
5	Neurological testing of motor function	Principles of muscle testing and differentiation from other muscle dysfunctions
6	Neurological testing of sensory function	Methods of testing of principles of differentiation of nerve palsy from peripheral nerve and CNS disorders
7	Differential diagnosis from spinal scanning exam	Lumbo-sacral scanning examination clinical reasoning, with emphasis on muscle and neurologic tests
8	Differential diagnosis from lower extremity scans	Principles of interpretation of scanning examination findings with emphasis on selective tissue tension testing of lower quadrant extremity joints
9	Capsular patterns of restriction	Capsular patterns of restriction, especially of lower limb extremity joints
10	Signs & symptoms of serious pathology	Recognition of signs & symptoms of spinal neurological compromise or major vascular compromise
11	Indications and contraindications to OMPT	Indications and contraindications to OMPT intervention including suspicion of non-musculoskeletal origin of pain and MacNab's classification of pain (viscerogenic, vasculogenic etc)
12	Lumbo-sacral anatomy and biomechanics	Lumbo-sacral spine anatomy and biomechanics
13	Pathology of the lumbo-sacral region	Pathology and movement dysfunctions of the lumbo-sacral region
14	Lumbo-sacral spine clinical reasoning and OMPT treatment	Lumbo-sacral spine clinical reasoning, assessment and manual physical therapy interventions/ treatments
15	Biomechanics theories	Definitions and applied theory of osteokinematics, arthrokinematics, myokinematics and basic kinetics
16	Hip region anatomy and biomechanics	Hip region anatomy and biomechanics
17	Knee region anatomy and biomechanics	Knee region anatomy and biomechanics (tibio-femoral, patello-femoral and superior tibio-fibular)
18	Ankle and foot anatomy and biomechanics	Ankle and foot anatomy and biomechanics (inferior tibio-fibular, ankle, subtalar and major tarsal, MT & IP joints)
19	Lower extremity pathology	Lower extremity pathology and movement dysfunctions
20	Lower extremity clinical reasoning and OMPT treatment	Lower extremity clinical reasoning, assessment and manual physical therapy interventions/ treatments including grading of techniques

SAMPLE QUESTIONS FROM I-TESTS 500, 600 AND 610**SAMPLE #1. Mix and match [500]**

Match the following dermatomal areas of skin with the most appropriate spinal segment (answers A-E):

- | | |
|--|-----|
| 1. ulnar side of the forearm and hand | () |
| 2. lateral side of the face | () |
| 3. radial side of the forearm and hand | () |
| 4. axilla and the medial arm | () |
| 5. upper trapezius | () |

- A. C2
 B. C4
 C. C6
 D. C8
 E. T2

SAMPLE #2. Multiple choice [500]

Identify which of the following are typical signs of spinal cord compromise:

- A. spastic gait, hyporeflexia, fatiguing weakness
 B. spastic gait, hyperreflexia, fatiguing weakness
 C. spastic gait, hyperreflexia, clonus
 D. drop-foot gait, hyporeflexia, fatiguing weakness

SAMPLE #3. Multiple choice, null or negative question [500, 610]

A sign that would be atypical and would tend to rule out an underlying structural anomaly of the lumbar spine is:

- A. a 'café au lait' discoloration
 B. a 'port wine stain' discoloration
 C. a hair patch
 D. severe swelling

SAMPLE #4. Multiple choice [500, 600]

The capsular pattern of restriction of the elbow joint is most accurately described as a:

- A. greater loss of extension than flexion
 B. gross loss of flexion with full extension
 C. equal loss of flexion and extension
 D. greater loss of flexion than extension

SAMPLE #5. True-false [500, 600, 610]

In a sensory root palsy, the loss of skin sensitivity tends to occur towards the distal end of a dermatome.

- A. true
- B. false

SAMPLE #6. Multiple choice, null question [600]

Upper thoracic pain can be from a osteogenic cause. Which of the following is the least likely to be the source of the osteogenic pain

- A. posterolateral disc protrusion
- B. spondylosis
- C. end-plate fracture
- D. spinous process avulsion fracture

SAMPLE #7. Multiple choice, null question [600, 610]

The behavior of the pain can often suggest a serious pathology. Which of the following would be considered the most benign and the least serious pain descriptor.

- A. pain increases during sitting
- B. pain increases during eating
- C. pain wakes the patient from a deep sleep
- D. pain does not change with motion or position

SAMPLE #8. Multiple choice [600, 610]

When mobilizing a spinal joint with restrictive motion in which the pain occurs before the restriction barrier and half way into expected range, the preferred techniques is to utilize a combination of amplitudes of oscillatory techniques that include:

- A. grades II and III
- B. grades III and V
- C. grades IV and I
- D. grades V and IV

SAMPLE #9. Multiple choice [600,610]

The joint may be classified as a:

- A. compound modified sellar
- B. compound modified ovoid
- C. simple modified sellar
- D. simple modified ovoid

SAMPLE #10. Multiple choice [600,610]

The spurt muscle's primary function on the joint is:

- A. maintaining the loose pack position
- B. producing angular motion
- C. producing a spin motion
- D. transarticular stabilization

SAMPLE #11. Mix and match [610]

Match the best description (A-E) with the pathology or disorder

- Achilles tendonitis (tendonitis) ()
- thrombophlebitis of leg ()
- Achilles tendon tear ()
- Hoffa's disease of the fat pad ()
- Shin splints ()

- A. unable to walk, Thompson's calf test positive
- B. swelling around the tendon and joint line
- C. pain with walking, tenderness along tendon
- D. Homan's sign with calf pain and swelling
- E. exercise-induced medial leg pain

SAMPLE #12. Multiple choice [610]

A very effective mobilization technique to the tibia to regain the last five degrees of knee extension is one using an:

- A. anterior glide with lateral rotation
- B. anterior glide with medial rotation
- C. anterior rock with lateral rotation
- D. anterior rock with medial rotation

SAMPLE #13. True-false [600]

During supination of the superior radioulnar joint, the ulnar is not static and moves into a small amount of adduction

- A. true *
- B. false

SAMPLE #14. Multiple choice [600]

The ideal position of the patient's arm for effective deep transverse friction massage to the supraspinatus tendon at its insertion on the humerus is:

- A. 90 degrees abduction, 45 degrees internal rotation
- B. full internal rotation, with adduction and extension
- C. 90 degrees external rotation
- D. slight extension and external rotation

SAMPLE #15. Multiple choice, null question [500,600]

Cervical quadrant tests of extension with ipsilateral side bending and flexion with contralateral side-bending are often performed. These additional quadrant compression tests are added only if during the neutral compression test there is reproduction or aggravation of the:

- A. arm pain, but at no other time
- B. neck pain and arm pain, but at no other time
- C. arm pain, and a history of arm pain since the onset of their neck pain
- D. neck pain and no history of arm pain since the onset of neck pain

SAMPLE #16. Multiple choice [500,600, 610]

Within the scanning examination, isometric muscle tests are performed to examine:

- A. muscle strength on a 0-5 scale
- B. spinal nerve root conduction
- C. muscle endurance
- D. the power output of a muscle

