1. Moving the soft tissue toward a barrier on more than one plane is an example of:
   a. An indirect technique
   b. An interbarrier zone
   c. Strain Counter Strain
   d. A barrier technique
   e. A direct technique

2. The interbarrier zone is:
   a. Located a few degrees before the muscle barrier is engaged
   b. Before the muscle fibers go into spasm due to spindle action
   c. A loose packed position
   d. All of the above
   e. None of the above

3. According to Freyette, when motion is introduced in one plane:
   a. A uniplanar technique is created
   b. A tripalnlar technique is created
   c. Motion in all other planes is reduced
   d. Motion in all other planes is increased
   e. Motion in all other planes remains the same

4. It has been hypothesized that athletes have a higher incidence of sacroiliac dysfunction. This can be associated with
   a. Wolff’s Law
   b. To the increase incidences of direct blows and falls
   c. Freyette’s Law
   d. All of the above
   e. None of the above

5. The etiology of a sacroiliac joint dysfunction has been documented to include:
   a. Trauma
   b. Kinetic chain influences
   c. Decreased muscular performance
   d. Metabolic conditions
   e. All of the above

6. The inferior lateral angle (ILA) of the sacrum is located at the level of:
   a. S2
   b. S3
7. The transitional vertebrae variation sacralization indicates:
   a. There are only four lumbar vertebra
   b. There are six sacral vertebra
   c. There is an alteration in the biomechanics of the back
   d. All of the above
   e. None of the above

8. Iliosacral motion refers to:
   a. The ilium moving on the sacrum
   b. Standing trunk flexion and extension
   c. Seated trunk flexion and extension
   d. A & B
   e. B & C
   f. None of the above

9. An upslip is considered which type of motion?
   a. Sacroiliac
   b. Sacro-pubic
   c. Pubo-sacral
   d. Ilio-sacral

10. Sacral torsions occur on the:
    a. Oblique sacral axis
    b. The oblique ilial axis
    c. The sacral vertical axis
    d. The horizontal sacral axis

11. With normal mechanics, when one limb is fully weight bearing, the sacrum:
    a. Remains vertical
    b. Is in full backward torsion
    c. Sacral motion is not important
    d. Is in full forward torsion

12. Which of the following is not an integrated part of evidence-based medicine according to Sackett et al. (2000)?
    a. Clinical experience
    b. Patient values
    c. Best research evidence
    d. Insurance company wishes
13. Which of the following statistics is commonly used to describe the validity of a diagnostic test result?
   a. Kappa
   b. ANOVA
   c. Sensitivity
   d. T-test

14. Specificity is a measure of the _________________.
   a. proportion of people with a disorder who have a positive test
   b. proportion of people without the disorder who have a negative test
   c. number of people in a population who have the disorder
   d. number of people with the disorder who will respond to a specific treatment

15. If a diagnostic test has high sensitivity, a negative result ________.
   a. rules in the disorder
   b. indicates low irritability of the disorder
   c. rules out the disorder
   d. indicates high irritability of the disorder

16. The highest level of evidence used to make evidence-based medicine decisions is _________________.
   a. expert opinion
   b. a textbook chapter
   c. a systematic review with homogeneous randomized controlled trials
   d. a case study

17. Which of the following types of diagnostic tests are considered most reliable and valid with regard to diagnosing sacroiliac joint pain in chronic low back patients?
   a. Landmark palpation
   b. Motion palpation
   c. Pain location
   d. Pain provocation

18. Muscle energy technique has been shown to increase range of motion in:
   a. patients with cervical somatic dysfunction
   b. asymptomatic subjects with restrictions of lumbar extension range of motion
   c. patients with sacroiliac joint pain
   d. patients with thoracic pain

19. A clinical prediction rule is a set of diagnostic criteria that are used to identify patients (with a high degree of probability) that:
   a. will respond to a specific treatment
   b. are malingerers
c. have sacroiliac joint pain
d. have lumbar disc involvement

20. When positioning the individual for a MET release to the lumbar spine the clinician instructs the individual being treated to contract:
   a. as hard as possible
   b. only within pain limitations
   c. very lightly
   d. contract until they feel mild discomfort

21. The term gamma gain refers to:
   a. the amount of tension in the joint capsule holding the joint in dysfunction
   b. the amount of muscular activity occurring in the muscular tissue holding the joint in a dysfunctional position
   c. the level with which the individual being treated contracts the muscles surrounding the joint being mobilized
   d. a relax/contraction occurrence

22. When using MET the clinician instructs the individual being treated to hold their respective contractions:
   a. approximately 3 seconds
   b. approximately 6 seconds
   c. approximately 10 seconds
   d. as long as the individual can hold without feeling pain

23. Neutral position in the muscle energy world refers to:
   a. the position of least contracted muscle spindles
   b. the point of balance of an articular surface from which all the motions physiologic to that articulation may take place
   c. when a muscle receives a nerve impulse to contract
   d. antagonist vs. agonist contraction

24. Hilton’s Law refers to the concept of:
   a. muscles contract only as hard as the nerve impulse requires
   b. muscle contraction is overtly affected by the dermatomes surrounding that particular muscle
   c. the nerves innervating a joint also innervate the muscles over that joint and the skin over their insertion
   d. the point of balance of a particular joint requires that the muscles surrounding that joint be isometrically contracted during the treatment phase

25. Closed packed position refers to the concept that:
   a. various tissues around the joint are under tension, thus the joint is under tension and most vulnerable
b. joint receptors are under tension thus requiring the use of acupressure to release the joint

c. joint limitations are respective of the sodium/potassium balance within the muscle spindles
d. none of the above

26. Upon examination, a facet pathology will present with the following findings:
   a. Pain with lumbar flexion
   b. Pain with lumbar extension and limited rotation
   c. Pain with lumbar flexion and side bending away from the side of the lesion
   d. Pain with lumbar extension and side bending away from the side of the lesion

27. According to Mr. Marek, one of most common problems with treating the iliopsoas complex is:
   a. the iliopsoas is connected neurologically to the quadratus lumborum
   b. the iliopsoas muscle contracts only in conjunction with the piriformis
   c. the iliopsoas muscle lies deep to the abdomen originating from the lateral aspects of the transverse processes of the five lumbar vertebra
   d. none of the above

28. When examining the individual for a possible lumbar lesion you notice the individual’s fourth lumbar vertebrae rotates to the left in extension—meaning that the individual is:
   a. stuck in flexion and rotated left
   b. stuck in extension and rotated left
   c. stuck in flexion and rotated right
   d. stuck in flexion and rotated forward

29. The most common ilial dysfunction is:
   a. Posterior ilial rotation dysfunction
   b. Anterior ilial rotation dysfunction
   c. Downsips
   d. Outflares

30. With anterior ilial rotation dysfunction, upon examination you will most likely find:
   a. Pain in the low back, lateral hip and anterior-medial lower leg
   b. Pain in the groin, medial knee and ankle
   c. A functional short leg
   d. A functional long leg
31. With posterior ilial rotation dysfunction, upon examination you will most likely find:
   a. ASIS superior, PSIS inferior, deep sacral sulcus
   b. ASIS inferior, PSIS superior, shallow sacral sulcus
   c. ASIS superior, PSIS inferior, shallow sacral sulcus
   d. ASIS medial, PSIS lateral, wide sacral sulcus

32. With an in-flare dysfunction, upon examination you will most likely find:
   a. A toe-in with increased anterior pelvic rotation in gait
   b. A toe-out with increased contralateral anterior pelvic rotation in gait
   c. A functional short leg
   d. A functional long leg

33. With an upslip dysfunction:
   a. Only the PSIS and iliac crest will be superior
   b. Only the ASIS and iliac crest will be superior
   c. You almost always will find an associated rotation dysfunction
   d. You will see an associated limitation in hip rotation and knee extension

34. Using MET, to correct for an anterior ilial rotation dysfunction the muscles used are:
   a. Iliacus, Psoas
   b. Hip internal rotators
   c. Hamstrings, Gluteals
   d. Hip adductors

35. Using MET, to correct for an in-flare dysfunction the muscles used are:
   a. Gluteals
   b. Iliacus
   c. Hip internal rotators
   d. Abdominals

36. According to Ms. Boyle-Walker, when using MET to correct for upslips with anterior ilial rotation dysfunctions, position the patient:
   a. Sidelying
   b. Sitting
   c. Prone
   d. Supine

37. If you try to correct for a dysfunction and you see that there is no improvement, you should try:
   a. Electrical stimulation
   b. Releasing soft tissues and “wiggle” the SIJ
   c. Traction
38. The sacral base moves ________ with sacral nutation.
   a. backward out of the pelvis
   b. forward into the pelvis
   c. laterally away from the ipsilateral innominate
   d. superiorly

39. Which of the following ligaments does not limit sacral nutation?
   a. Sacrotuberous
   b. Interosseous
   c. Sacrospinous
   d. Long dorsal (posterior) sacroiliac

40. With an anterior ilial rotation dysfunction, upon examination you will most likely find:
   a. Tenderness in the posterior sacroiliac ligament
   b. Tenderness in the sacrotuberous ligament
   c. Hypertonic hamstrings
   d. Tenderness in the inguinal ligament

41. During normal gait mechanics, L5 and the sacrum move in _______________.
   a. the same direction
   b. opposite directions
   c. congruent directions
   d. equal directions

42. Which pelvic landmarks are used to identify sacroiliac joint dysfunctions?
   a. ASIS and PSIS
   b. ASIS and ILA
   c. Sacral Sulcus and ILA
   d. Sacral sulcus and PSIS

43. What palpatory finding is used for determining the direction of a sacral torsion?
   a. Piriformis tone
   b. ILA depth
   c. Sacral sulcus depth
   d. PSIS position

44. What muscle is typically hypertonic involved in forward sacral torsion dysfunctions?
   a. Multifidus
   b. Piriformis
   c. Iliopsoas
   d. Ultrasound
d. Tensor fascia lata

45. According to Mr. Miller, which of the following tests is not used to determine the side of the pelvic dysfunction?
   a. Sit-to-supine test (malleoli position)
   b. Standing flexion test
   c. Gillet’s test
   d. Seated flexion test