

# Common back translation-Bruxscreen

## Appendix 1:

### BruxScreen

#### Part 1: BruxScreen-Q (Bruxism Screener) Self-Report questionnaire

Explanation:

This questionnaire screens for possible bruxism and associated orofacial symptoms.

Bruxism is a masticatory muscle activity that can manifest in two different ways: clenching, which involves light or forceful contact between the opposing teeth or grinding. While during tooth grinding the lower jaw moves from side to side against the upper jaw, in clenching the lower jaw moves very little. Additionally, tooth grinding is usually accompanied by noise. These different muscle activities can occur during wakefulness and/or during sleep. Usually, bruxism activity is harmless, but some individuals may suffer from associated issues such as jaw pain, masticatory muscle stiffness, or limited mouth opening. Please complete this short questionnaire so your dentist can determine if you engage in this muscle activity. Please provide the completed questionnaire to your dentist, who will then examine your jaws and teeth to confirm the condition you reported in the questionnaire.

Thank you for your cooperation.

Your Dentist

#### 1. Bruxism

a. How often do you clench your teeth during sleep?

☐ Never ☐ Sometimes ☐ Regularly ☐ Very Often ☐ Always ☐ Don't know

b. How often do you grind your teeth during sleep?

☐ Never ☐ Sometimes ☐ Regularly ☐ Very Often ☐ Always ☐ Don't know

c. How often do you clench your teeth when awake?

☐ Never ☐ Sometimes ☐ Regularly ☐ Very Often ☐ Always ☐ Don't know

d. How often do you grind your teeth when awake?

☐ Never ☐ Sometimes ☐ Regularly ☐ Very Often ☐ Always ☐ Don't know

e. How often do you lightly press, clench, touch or hold your teeth together (i.e. tooth contact between upper and lower teeth) when awake at any time other than eating?

☐ Never ☐ Sometimes ☐ Regularly ☐ Very Often ☐ Always ☐ Don't know

f. How often do you forcefully hold, clench or feel tensed masticatory muscles when awake without tooth contact?

☐ Never ☐ Sometimes ☐ Regularly ☐ Very Often ☐ Always ☐ Don't know

#### 2. Orofacial Symptoms

a. How often do you experience pain/discomfort/tenderness/fatigue/tightness/stiffness in the jaw, face, masticatory muscles or temporomandibular joint (TMJ) area?

|                | Pain                                                                                                                                                                                                                        | Discomfort                                                                                                                                                                                                                  | Tenderness                                                                                                                                                                                                                  | Fatigue                                                                                                                                                                                                                     | Tightness                                                                                                                                                                                                                   | Stiffness                                                                                                                                                                                                                   |
|----------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Upon waking    | <input type="checkbox"/> never<br><input type="checkbox"/> sometimes<br><input type="checkbox"/> regularly<br><input type="checkbox"/> Very Often<br><input type="checkbox"/> always<br><input type="checkbox"/> don't know | <input type="checkbox"/> never<br><input type="checkbox"/> sometimes<br><input type="checkbox"/> regularly<br><input type="checkbox"/> Very Often<br><input type="checkbox"/> always<br><input type="checkbox"/> don't know | <input type="checkbox"/> never<br><input type="checkbox"/> sometimes<br><input type="checkbox"/> regularly<br><input type="checkbox"/> Very Often<br><input type="checkbox"/> always<br><input type="checkbox"/> don't know | <input type="checkbox"/> never<br><input type="checkbox"/> sometimes<br><input type="checkbox"/> regularly<br><input type="checkbox"/> Very Often<br><input type="checkbox"/> always<br><input type="checkbox"/> don't know | <input type="checkbox"/> never<br><input type="checkbox"/> sometimes<br><input type="checkbox"/> regularly<br><input type="checkbox"/> Very Often<br><input type="checkbox"/> always<br><input type="checkbox"/> don't know | <input type="checkbox"/> never<br><input type="checkbox"/> sometimes<br><input type="checkbox"/> regularly<br><input type="checkbox"/> Very Often<br><input type="checkbox"/> always<br><input type="checkbox"/> don't know |
| Any other time | <input type="checkbox"/> never<br><input type="checkbox"/> sometimes<br><input type="checkbox"/> regularly<br><input type="checkbox"/> Very Often<br><input type="checkbox"/> always<br><input type="checkbox"/> don't know | <input type="checkbox"/> never<br><input type="checkbox"/> sometimes<br><input type="checkbox"/> regularly<br><input type="checkbox"/> Very Often<br><input type="checkbox"/> always<br><input type="checkbox"/> don't know | <input type="checkbox"/> never<br><input type="checkbox"/> sometimes<br><input type="checkbox"/> regularly<br><input type="checkbox"/> Very Often<br><input type="checkbox"/> always<br><input type="checkbox"/> don't know | <input type="checkbox"/> never<br><input type="checkbox"/> sometimes<br><input type="checkbox"/> regularly<br><input type="checkbox"/> Very Often<br><input type="checkbox"/> always<br><input type="checkbox"/> don't know | <input type="checkbox"/> never<br><input type="checkbox"/> sometimes<br><input type="checkbox"/> regularly<br><input type="checkbox"/> Very Often<br><input type="checkbox"/> always<br><input type="checkbox"/> don't know | <input type="checkbox"/> never<br><input type="checkbox"/> sometimes<br><input type="checkbox"/> regularly<br><input type="checkbox"/> Very Often<br><input type="checkbox"/> always<br><input type="checkbox"/> don't know |

b. How often do you experience pain/discomfort/tenderness/fatigue/tightness/stiffness in the jaw, face, masticatory muscles or TMJ area during mouth opening or chewing?

|                | Pain                                                                                                                                                                                                                        | Discomfort                                                                                                                                                                                                                  | Tenderness                                                                                                                                                                                                                  | Fatigue                                                                                                                                                                                                                     | Tightness                                                                                                                                                                                                                   | Stiffness                                                                                                                                                                                                                   |
|----------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| During meals   | <input type="checkbox"/> never<br><input type="checkbox"/> sometimes<br><input type="checkbox"/> regularly<br><input type="checkbox"/> Very Often<br><input type="checkbox"/> always<br><input type="checkbox"/> don't know | <input type="checkbox"/> never<br><input type="checkbox"/> sometimes<br><input type="checkbox"/> regularly<br><input type="checkbox"/> Very Often<br><input type="checkbox"/> always<br><input type="checkbox"/> don't know | <input type="checkbox"/> never<br><input type="checkbox"/> sometimes<br><input type="checkbox"/> regularly<br><input type="checkbox"/> Very Often<br><input type="checkbox"/> always<br><input type="checkbox"/> don't know | <input type="checkbox"/> never<br><input type="checkbox"/> sometimes<br><input type="checkbox"/> regularly<br><input type="checkbox"/> Very Often<br><input type="checkbox"/> always<br><input type="checkbox"/> don't know | <input type="checkbox"/> never<br><input type="checkbox"/> sometimes<br><input type="checkbox"/> regularly<br><input type="checkbox"/> Very Often<br><input type="checkbox"/> always<br><input type="checkbox"/> don't know | <input type="checkbox"/> never<br><input type="checkbox"/> sometimes<br><input type="checkbox"/> regularly<br><input type="checkbox"/> Very Often<br><input type="checkbox"/> always<br><input type="checkbox"/> don't know |
| Any other time | <input type="checkbox"/> never<br><input type="checkbox"/> sometimes<br><input type="checkbox"/> regularly<br><input type="checkbox"/> Very Often<br><input type="checkbox"/> always<br><input type="checkbox"/> don't know | <input type="checkbox"/> never<br><input type="checkbox"/> sometimes<br><input type="checkbox"/> regularly<br><input type="checkbox"/> Very Often<br><input type="checkbox"/> always<br><input type="checkbox"/> don't know | <input type="checkbox"/> never<br><input type="checkbox"/> sometimes<br><input type="checkbox"/> regularly<br><input type="checkbox"/> Very Often<br><input type="checkbox"/> always<br><input type="checkbox"/> don't know | <input type="checkbox"/> never<br><input type="checkbox"/> sometimes<br><input type="checkbox"/> regularly<br><input type="checkbox"/> Very Often<br><input type="checkbox"/> always<br><input type="checkbox"/> don't know | <input type="checkbox"/> never<br><input type="checkbox"/> sometimes<br><input type="checkbox"/> regularly<br><input type="checkbox"/> Very Often<br><input type="checkbox"/> always<br><input type="checkbox"/> don't know | <input type="checkbox"/> never<br><input type="checkbox"/> sometimes<br><input type="checkbox"/> regularly<br><input type="checkbox"/> Very Often<br><input type="checkbox"/> always<br><input type="checkbox"/> don't know |

c. How often does your jaw get stuck or locked?

i. During meals: ☐ Never ☐ Sometimes ☐ Regularly ☐ Very Often ☐ Always ☐ Don't know

ii. Any other time: ☐ Never ☐ Sometimes ☐ Regularly ☐ Very Often ☐ Always ☐ Don't know

## Part 2: BruxScreen-C Clinical Bruxism Screener

Explanation:

The purpose of this diagnostic tool is to diagnose signs that may be associated with bruxism. First, an extraoral examination of the masseter muscles should be performed to check for masseter muscle hypertrophy. The examination is initially done with the muscles at rest and then with the muscles contracted (teeth clenched). In case of doubt, choose the "none" option.

Next, an intraoral examination should be performed to look for signs of bruxism. Again, in case of any doubt, choose the "none" option. Finally, the dentition should be examined, and the degree of tooth wear recorded as indicated on the form. In case of doubt between two different degrees of wear, choose the lower degree. Also indicate whether the observed tooth wear is primarily mechanical (e.g. due to tooth-to-tooth contact - matching facets) or chemical-erosive wear, or both.

### 1. Extraoral Examination

a. Masseter muscle hypertrophy (observed with masseters at rest)

☐ Present ☐ None

b. Masseter muscle hypertrophy (observed with masseters contracted)

☐ Present ☐ None

## 2. Intraoral Examination

a. Lip (indentations)

☐ Present ☐ None

b. Cheek (linea alba)

☐ Present ☐ None

c. Tongue (indentations)

☐ Present ☐ None

d. Tongue (traumatic lesions)

☐ Present ☐ None

e. Alveolar bone (exostoses/tori)

☐ Present ☐ None

## 3. Intraoral Examination - Dentition

a. Occlusal/incisal wear per sextant

(0) No visible wear, (1) Wear involving enamel only, (2) Wear with exposed dentin and clinical crown height loss  $\leq 1/3$ , (3) Wear with exposed dentin and clinical crown height loss  $> 1/3$  but  $< 2/3$ , (4) Wear with exposed dentin and clinical crown height loss  $\geq 2/3$

b. Palatal wear on sextant 2:

(0) No palatal wear visible, (1) Enamel wear, (2) Exposed dentin wear

| Sextant 1 – occlusal | Sextant 2 – incisal | Sextant 3 – occlusal |
|----------------------|---------------------|----------------------|
| 0 1 2 3 4            | 0 1 2 3 4           | 0 1 2 3 4            |
|                      | Sextant 2 - palatal |                      |
|                      | 0 1 2               |                      |
| Sextant 6 – occlusal | Sextant 5 – incisal | Sextant 4 – occlusal |
| 0 1 2 3 4            | 0 1 2 3 4           | 0 1 2 3 4            |

c. The observed tooth wear is: ☐ Primarily mechanical, ☐ Primarily chemical, ☐ Both mechanical and chemical