Common back translation-STAB

STAB Bruxism Diagnostic Questionnaire

The questionnaire is phrased in the masculine form but refers to both women and men.

[TS7] הערות עם: Although this sentence does not exist in the source file, In order to be gender fair we had to use it at the top of the questionnaire.
This problem does not exist in the English language

Demographics

Sex

Male

Female

Other

Age_____ Height_____ Weight_____

Current marital status?

Married

Living together as married

Divorced

Separated

Widowed

Never married

For Israeli citizens:

[TS8] הערות עם: This paragraph is an addition according to the population register of the State of Israel.

What ethnic origin best describes you?

Jewish

Muslim

Christian

Druze

Bedouin

Circassian

Other specify_____

[TS9] הערות עם: This sentence is an addition for Foreign citizens.

For foreign nationals: Please specify your nationality_____

What is your education level (indicate the highest level completed)?

[TS10] הערות עם: This sentence is an addition in accordance with the education system in Israel

Compulsory education only (less than 12 years of schooling)

Full high school matriculation

Academic studies without a degree

Bachelor's degree (BA)

Master's degree or higher (MA, PhD,...)

Axis A - Bruxism Assessment and Implications

Self-Report Questionnaire - To be completed by the patient

A1. Sleep Bruxism Report

A1.1. Based on the last month, how often do you clench or grind your teeth during sleep (based on any information you have)?

Never

Less than 1 night/month

1-3 nights/month

1-3 nights/week

4-7 nights/week

Don't know

A1.1.1. Did you clench or grind your teeth while asleep in the past, based on any information you have?

No

Yes

Don't know

A2. Awake Bruxism Report

A2.1 Question about tooth grinding while awake

Based on the last month, how often do you grind your teeth while awake?

Never

A little of the time

Some of the time

Most of the time

All of the time

Don't know

A2.1.1 Question about past tooth grinding while awake

Did you used to grind your teeth while awake in the past?

No

Yes

Don't know

A2.2 Question about teeth clenching while awake

Based on the last month, how often do you clench your teeth while awake?

Never

A little of the time

Some of the time

Most of the time

All of the time

Don't know

A2.2.1 Question about past teeth clenching while awake

Did you used to clench your teeth while awake in the past?

No

Yes

Don't know

A2.3 Question about teeth contact while awake

Based on the last month, how often do you press, touch, or bring opposing teeth into full contact when not eating (i.e., there is contact between upper and lower teeth)?

Never

A little of the time

Some of the time

Most of the time

All of the time

Don't know

A2.3.1 Question about past teeth contact while awake

Did you used to press, touch, or bring opposing teeth into full contact when not eating (i.e., there was contact between upper and lower teeth)?

No

Yes

Don't know

A2.4 Question about jaw clench while awake

Based on the last month, how often do you hold, tighten, or contract your muscles, without any tooth-to-tooth contact?

Never

A little of the time

Some of the time

Most of the time

All of the time

Don't know

A2.4.1 Question about past jaw clench while awake

Did you used to hold, clench, or contract your muscles, without clenching or tooth-to-tooth contact?

No

Yes

Don't know

A3. Patient Complaints

Functional Disorders of the Masticatory System

A3.1 TMD Pain

During the last 30 days, how long did you experience pain in the jaw or temple area on either side or both sides?

No pain

The pain comes and goes

The pain is always present

A3.2 Pain or Stiffness upon Waking

During the last 30 days, did you experience jaw pain or stiffness upon awakening?

No

Yes

A3.3 Closed Lock

During the last 30 days, did your jaw get stuck or locked, even momentarily, so that you could not open your mouth fully?

No

Yes

A3.4 Change in Pain with Jaw Activity

During the last 30 days, which of the following activities changed the pain (i.e., made it better or worse) in the jaw or temple area on either side or both sides?

Chewing hard or crunchy foods

Opening the mouth or moving jaw forward or to the side

Habits such as holding teeth together, clenching, grinding teeth, or chewing gum

Other jaw activities such as talking, kissing, or yawning

A3.5 Joint Sounds

During the last 30 days, did you notice any jaw joint sounds when you moved or used your jaw?

No

Yes

A3.6 Muscle Pain Upon Waking

During the last 30 days, did you experience facial muscle pain at any of the following times?

Between waking and breakfast

Between breakfast and lunch

[TS11] הערות עם: A consistent comment by all the editors - it is not clear how to answer the questions without yes/no answers, and they recommended to add NO\YES answers.

Between lunch and dinner

Between dinner and bedtime

A3.6.1 Fatigue/Tiredness or Weakness of Jaw Muscles Upon Waking

During the last 30 days, did you experience fatigue/tiredness or weakness of your jaw muscles at any of the following times?

A consistent comment by all the editors - it is not clear how to answer the questions without yes/no answers, and they recommended to add NO\YES answers. **[TS12] עם הערות:**

Between waking and breakfast

Between breakfast and lunch

Between lunch and dinner

Between dinner and bedtime

A3.7 Awake Symptom Questionnaire

Are you aware of any of the following symptoms upon waking:

[TS13] הערות עם: A consistent comment by all the editors - it is not clear how to answer the questions without yes/no answers, and they recommended to add it.

Feeling of fatigue, jaw pain or tightness, feeling that teeth are clenched, and mouth is sore

Pain in the temple area

A feeling of tightness in the lower jaw upon waking so that there is a need to move it side-to-side to release the jaw

Difficulty to open the mouth wide upon waking

Hearing or feeling a click (noise) upon waking when moving the lower jaw (opening mouth or moving it side-to-side) that goes away after

Headache

A3.8 Headache

During the last 30 days, did you experience headaches that included the temple area?

No

Yes

If yes – how many days?

Tooth Wear

A3.9 Tooth Wear

Do you experience any of the following symptoms due to tooth wear?

Sensitivity and/or pain

Functional problems (difficulty chewing and eating)

Esthetic concerns (affected appearance of teeth)

Chipping or cracking of teeth or restorations (fillings)

Speech difficulties

[TS14] הערות עם: A consistent comment by all the editors - it is not clear how to answer the questions without yes/no answers, and they recommended to add NO\YES answers

Tinnitus

A3.10 Tinnitus : ringing, buzzing or noises in the ears when there is no external noise at all.

Do you hear noises or ringing in your ears (tinnitus)?

No

Yes

[TS15] עם הערות:
A consistent comment by all the editors and the was that not all the dentists in Israel understand or control the meaning of Tinnitus , Hence, they recommended to add the definition of Tinnitus: ringing, buzzing or noises in the ears when there is no external noise at all.

Dry Mouth and Drooling

A3.11 Dry Mouth

Do you experience a dry mouth?

Never

Sometimes

Often

A3.12 Drooling

Do you experience drooling (unintentional release of saliva from the mouth) during sleep?

I do not experience any drooling during sleep

My pillow gets wet occasionally during sleep

My pillow gets wet regularly during sleep

My pillow gets wet always during sleep

Every night my pillow as well as the bedsheets get wet

Clinical Assessment - To be completed by the examiner

A4. Joints and Muscles

A4.1 TMD Diagnoses

Please indicate the presence of the following diagnoses

A4.1.1 Pain Disorders

This section should only be marked if question A3.3 was answered positively by the patient.

Myalgia

Myofascial pain with spreading

Myofascial pain with referral

Right arthralgia

Left arthralgia

Headache attributed to TMD

A4.1.2 Right Joint Disorders

Please indicate if the diagnosis is based on clinical examination or imaging

Clinical examination only_____

Additional imaging_____

Disc displacement with reduction

Disc displacement with reduction, with intermittent locking

Disc displacement without reduction with limited opening

Disc displacement without reduction without limited opening

Degenerative joint disease

Subluxation

A4.1.3 Left Joint Disorders

*Please indicate if the diagnosis is based on clinical examination or imaging

Clinical examination only_____

Additional imaging_____

Disc displacement with reduction

Disc displacement with reduction, with intermittent locking

Disc displacement without reduction with limited opening

Disc displacement without reduction without limited opening

Degenerative joint disease

Subluxation

A4.2 Masseter Muscle Hypertrophy

Indicate the presence of masseter hypertrophy

Left

Right

A5. Intraoral Tissues and Facial Profile

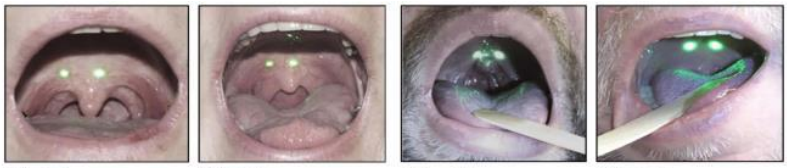
A5.1 Soft and Hard Tissues

Please indicate the presence of the following markers:

Linea Alba (marking on the inside of the cheeks)	Left	Right	
Tooth markings on the lip:	Upper	Lower	
Tooth markings on the tongue	Left	Right	Center
Tongue ulcer	Left	Right	Center
Mandibular Alveolar Bone Exostosis	Buccal	Lingual	
Maxillary Alveolar Bone Exostosis	Buccal	Lingual	Palatal Center

[TS16] הערות עם: This explanation of Linea alba was added because some dentists who participated in STEP 10 noted that not all their colleagues are familiar with Latin terms.

A5.2 Modified Friedman Tongue Position



Category I:
No phonation/ tongue depressor – uvula and palatal arch visible

Category II:
With phonation – uvula and palatal arch visible

Category III:
With tongue depressor – uvula and palatal arch visible

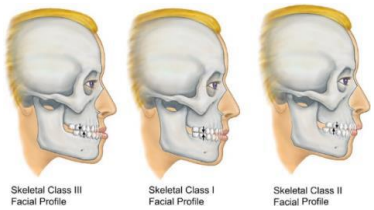
Category IV:
With phonation/ tongue depressor – uvula and palatal arch not visible

A5.3 SKELETAL CLASS (Optional Item)

Class 1

Class 2

Class 3



Skeletal Class III Facial Profile

Skeletal Class I Facial Profile

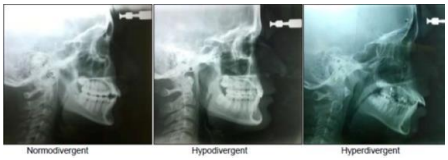
Skeletal Class II Facial Profile

A5.4 SKELETAL PROFILE (Optional Item)

Normodivergent profile (medlium gonial angle)

Hypodivergent profile (low gonial angle)

Hyperdivergent profile (high gonial angle)



Normodivergent

Hypodivergent

Hyperdivergent

A6. Teeth and Restorations

A6.1 Quantitative Wear Assessment

Indicate the highest score in each sextant

	Sextant 1 (18-14)		Sextant 2 (13-23)		Sextant 3 (24-28)	
	Occlusal		Incisal		Occlusal	
			Sextant 2			
			Palatinal			
	Sextant 6 (48-44)		Sextant 5 (43-33)		Sextant 4 (34-38)	
	Occlusal		Incisal		Occlusal	

For occlusal/incisal surfaces, record the highest score

0 = No visible wear

1 = Wear visible in enamel

2 = Wear with exposed dentin and loss of clinical crown height ≤1/3

3 = Wear with exposed dentin and loss of clinical crown height >1/3 but <2/3

4 = Wear with exposed dentin and loss of clinical crown height ≥2/3

For non-occlusal/non-incisal surfaces, record the highest score

Grade 0 = No visible wear

Grade 1 = Wear visible in enamel

Grade 2 = Wear with dentin exposure (<50% of surface)

Grade 3 = Wear with dentin exposure (≥50% of surface)

Grade 4 = Wear with dentin exposure (complete loss of enamel or pulp exposure)

A6.1.1 Additional Tooth Wear Details

If in any sextant the wear score was found to be ≥2, further details are needed as follows:

Smooth glossy facets

Wear in enamel and dentin at the same degree

Matching facets on opposing occlusal surfaces in contact with each other

Cupping/fractures on cusp tips or restorations

Indentations on cheeks, tongue and/or lips

NCCL - Lesion located in non-carious cervical areas

NCCL - Buccal/cervical location wider than deep

Involvement of cervical areas and cusp ridges of premolars

Enamel cracks

Mandibular tori

A6.2 Periodontal Examination and Tooth Examination

Please indicate the tooth numbers with the following signs:

	Sextant 1	Sextant 2	Sextant 3	Sextant 4	Sextant 5	Sextant 6
Mobility						
Sensitivity to hot/cold						
Discomfort/pain on chewing						
Fractured teeth						

A6.3 Restorations

Please indicate the tooth numbers with the following signs:

	Sextant 1	Sextant 2	Sextant 3	Sextant 4	Sextant 5	Sextant 6
Lost/broken fillings						
Scratched restorations						
Ceramic fractures						
Mobile implants						
Implant fractures						
Implant screw loosening						

A6.4 Occlusal Guard Assessment (if occlusal guard is hard)

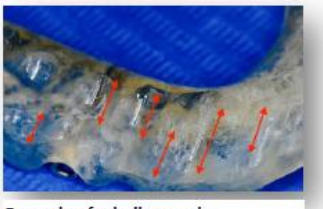
Please indicate the following signs:

Presence of grinding facets (e.g. grooved lines): Left Right Anterior

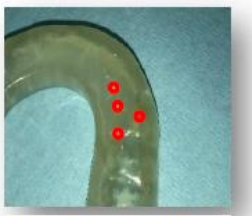
Presence of clenching facets (e.g. rounded indentations): Left Right Anterior

Combination of grinding and clenching facets: Left Right Anterior

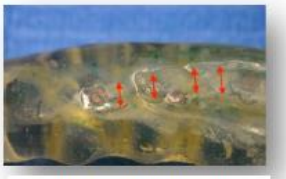
Fractures or perforations: Left Right Anterior



Example of grinding marks



Example of clenching marks.



Example of combined marks.

Technology-Based Instrumentation Assessment

A7. Sleep Bruxism

A7.1 Electromyography (EMG)

Number of masseter events over 10% MVC _____

Bruxism time index (if available) _____

Bruxism work index (if available) _____

A7.2 Polysomnography (Optional)

Number of arousal-related SB events _____

Number of arousal-unrelated SB events _____

Bruxism time index (if available) _____

Bruxism work index (if available) _____

A7.3 Other Methods (Optional)

Smartphone application scores for grinding sounds.

A7.4 Sensor-Embedded Guard (Optional)

Number of events of bite pressure

A8. Awake Bruxism

A8.1 Ecological Momentary Assessment (EMA)

Condition	Week 1 (%)	Additional Week (%)
Jaw muscles relaxed (no tooth contact)		
Jaw clenching while awake (no tooth contact)		
Tooth clenching while awake (light, stable contact)		
Tooth clenching while awake (forceful, stable contact)		
Tooth grinding		

A8.2 Electromyography (EMG) During Wakefulness

Number of masseter events over 10% MVC _____

Bruxism time index _____

Bruxism work index_____

A8.3 Additional Methods

A9. Additional Tools

A9.1 Intraoral Acidity Assessment (Optional)

Saliva pH at rest _____

Saliva flow rate at rest ____

Saliva pH upon stimulation _____

Saliva flow rate upon stimulation ____

Axis B - Risk Factors, Etiological Factors, Associated Conditions

B.1 Psychosocial Assessment

B1.1 Screening for Anxiety and Depression

Over the last 2 weeks, how often have you been bothered by any of the following problems?

1. Feeling nervous, anxious, or on edge

Not at all

Several days

More than half the days

Nearly every day

2. Not being able to stop or control worrying

Not at all

Several days

More than half the days

Nearly every day

3. Little interest or pleasure in doing things

Not at all

Several days

More than half the days

Nearly every day

4. Feeling down, depressed, or hopeless

Not at all

Several days

More than half the days

Nearly every day

B1.2 Coping

Consider to what extent the following statements describe your behaviors and actions:

1. I look for creative ways to alter difficult situations.

Does not describe me at all

Does not describe me

No opinion

Describes me

Describes me very well

2. Regardless of what happens to me, I believe I can control my reaction to it.

Does not describe me at all

Does not describe me

No opinion

Describes me

Describes me very well

3. I believe I can grow in positive ways by dealing with difficult situations.

Does not describe me at all

Does not describe me

No opinion

Describes me

Describes me very well

4. I actively look for ways to replace the losses I encounter in life.

Does not describe me at all

Does not describe me

No opinion

Describes me

Describes me very well

B2. Identifying Sleep-Related Conditions

B2.1 STOP BANG Questionnaire

Please mark which of the following questions is answered positively

[TS17] הערות עם: A consistent comment by all the editors - it is not clear how to answer the questions without yes/no answers, and they recommended to add NO\YES answers.
.

Do you snore loudly?

Do you often feel tired or sleepy during the day?

Has anyone observed you stop breathing or choking/gasping during sleep?

Are you being treated or have you been treated for high blood pressure?

[TS18] הערות עם: A consistent comment by all the editors
was that most patients don't know their BMI, and they recommended that patients provide their height and weight, and the dentist will calculate the BMI
Height: _____
Weight:_____.

BMI >35?

Age older than 50?

Neck circumference (43 cm or shirt size L for men. 41 cm or shirt size L for women)

Gender=male?

B2.2 Insomnia Screening

Please indicate which of the following statements describe your condition:

I have difficulty falling asleep

Thoughts race through my mind and prevent me from sleeping

I experience difficulty sleeping several times a week

I wake up and cannot go back to sleep

I worry about things and have difficulty calming down

I wake up early in the morning earlier than I would like

I lie awake for half an hour or more before I fall asleep

B2.3 Screening for Periodic Limb Movement Disorder (PLMD) and Restless Legs Syndrome (RLS)

Please indicate which of the following statements describe your condition:

Apart from during physical exercise, I feel restlessness in my legs

I have noticed (or others have commented) that parts of my body twitch/move/jerk during sleep

I have been told that I kick during sleep

When trying to sleep, I experience uncomfortable sensations of pain or heaviness in my legs

I experience leg pains and cramping sensations during the night

Sometimes I cannot keep my legs still or motionless during the night, I feel tired during the day

B2.4 Oral Behaviors - Sleep Posture

Based on the last 30 days, how often do you sleep in a posture that puts pressure on your jaws?

Never

A little of the time

Some of the time

Most of the time

All of the time

B3. Identifying Non-Sleep Related Conditions

Self-Report

B3.1 Oral Behaviors ACTIVITIES DURING WAKING HOURS

How often do you do each of the following activities, based on the last month?

Q7. Holds or protrudes jaw forward or to the side

Never

A little of the time

Some of the time

Most of the time

All of the time

Don't know

Q8. Thrusts tongue forcefully against teeth

Never

A little of the time

Some of the time

Most of the time

All of the time

Don't know

Q9. Places tongue between teeth

Never

A little of the time

Some of the time

Most of the time

All of the time

Don't know

Q10. Bites, chews or plays with tongue, cheeks or lips

Never

A little of the time

Some of the time

Most of the time

All of the time

Don't know

Q11. Holds jaw in a tense or strained position to brace or protect jaw

Never

A little of the time

Some of the time

Most of the time

All of the time

Don't know

Q12. Holds objects between teeth or bites objects such as hair, pipe, pencil, pens, fingers, nails etc.

Never

A little of the time

Some of the time

Most of the time

All of the time

Don't know

Q13. Chews gum

Never

A little of the time

Some of the time

Most of the time

All of the time

Don't know

Q14. Plays a musical instrument that requires the use of the mouth or jaw (e.g. wind instrument, stringed instrument)

Never

A little of the time

Some of the time

Most of the time

All of the time

Don't know

Q15. Leans with hand on the jaw, such as cupping or resting chin in the palm of the hand

Never

A little of the time

Some of the time

Most of the time

All of the time

Don't know

Q16. Chews food on one side only

Never

A little of the time

Some of the time

Most of the time

All of the time

Don't know

Q17. Snacks between meals

Never

A little of the time

Some of the time

Most of the time

All of the time

Don't know

Q18. Extended speaking (e.g. teaching, sales, customer service)

Never

A little of the time

Some of the time

Most of the time

All of the time

Don't know

Q19. Singing

Never

A little of the time

Some of the time

Most of the time

All of the time

Don't know

Q20. Yawning

Never

A little of the time

Some of the time

Most of the time

All of the time

Don't know

Q21. Holds telephone between head and shoulders

Never

A little of the time

Some of the time

Most of the time

All of the time

Don't know

B3.2 Use of mobile phone (optional)

Average screen time/day _____

B3.3 Orofacial Motor Disorders

Do you suffer or have you been diagnosed with any of the following conditions?

Orofacial Dyskinesia

Oromandibular Dystonia

Parkinson's Disease

Huntington's Disease

Tourette's Syndrome

Hemifacial Spasms

Tardive Dyskinesia

B3.4 Identification of Gastroesophageal Reflux

How many days per week do you experience the following symptoms?

a. Burning sensation behind breastbone (heartburn)

0 days

1 day

2-3 days

4-7 days

b. Stomach contents coming up into throat or mouth (regurgitation)

0 days

1 day

2-3 days

4-7 days

c. Pain in upper or middle abdomen

0 days

1 day

2-3 days

4-7 days

d. Nausea

0 days

1 day

2-3 days

4-7 days

e. Sleep problems due to heartburn or regurgitation

0 days

1 day

2-3 days

4-7 days

f. Need for over-the-counter antacids or reflux medication

0 days

1 day

2-3 days

4-7 days

B3.5 Screening for Autoimmune/Connective Tissue Diseases

Have you been diagnosed with any of the following conditions?

Rheumatoid Arthritis

Lupus

Other rheumatic diseases including fibromyalgia

Other systemic diseases, including systemic sclerosis, rheumatic polymyalgia, mixed connective tissue disease

B3.6 Attention Deficit Hyperactivity Disorder (ADHD)

Have you been diagnosed with Attention Deficit Hyperactivity Disorder (ADHD)?

No

Yes

B4. Prescription Medications and Substance Use

Self-Report

B4.1 Substances

Please indicate if you use any recreational/street drugs for social purposes.

If yes, please list which substances you use socially _____

B4.2 Medications

Are you currently taking any of the following medications?

Antidepressants (e.g., Selective serotonin-reuptake inhibitors)

Benzodiazepines

Neuroleptics, Antipsychotics, Antiemetics (Dopamine antagonists)

ADHD medication

Anti-allergic medication

Medical marijuana CBD

Medical marijuana THC

Opioids

Other_____

If yes, please list the medication names and dosages _____

B4.3 Tobacco

Do you smoke or use tobacco products?

No

Yes

Quit

If yes, how many cigarettes/day? Number _____

B4.4 Alcohol

Do you drink alcoholic beverages (beer, wine, liquor)?

No

Yes

Quit

If yes, what is your average daily consumption (drinks/day)? _____

B4.5 Soft Drinks

Do you regularly consume carbonated soft drinks (e.g. cola, Red Bull, Sprite, Fanta)?

No

Yes

Quit

If yes, what is your average daily consumption (drinks/day)? _____

B4.6 JUICES AND FRUITS

Do you regularly drink juices or citric fruits (e.g., lemon, orange, grapefruit)?

No

Yes

Quit

If yes, what is your approximate intake (glasses/day)? _____

B4.7 CAFFEINATE

Do you regularly drink coffee, tea, or other caffeine beverages?

No

Yes

Quit

If yes, what is your approximate intake (cups/day)? _____

B5. Identification of Additional Familial Factors

B5.1 Family History of Bruxism

Are you aware of anyone in your family (e.g. father, mother, children) who grinds or clenches their teeth (bruxism)?

No

Yes Father/Mother/Son/Daughter/Grandparent

Don't know

B5.2 Family History of Tooth Wear

Are you aware of anyone in your family (e.g. father, mother, children) with significant tooth wear?

No

Yes Father/Mother/Son/Daughter/Grandparent

Don't know

B5.3 Family History of Sleep Apnea

Are you aware of anyone in your family (e.g. father, mother, children) who has obstructive sleep apnea (OSA)?

No

Yes Father/Mother/Son/Daughter/Grandparent

Don't know

B5.4 Family History of Facial/Jaw Pain

Are you aware of anyone in your family (e.g. father, mother, children) with non-dental facial pain?

No

Yes Father/Mother/Son/Daughter/Grandparent

Don't know

B5.5 Family History of Reflux

Are you aware of anyone in your family (e.g. father, mother, children) diagnosed with reflux (GERD)?

No

Yes Father/Mother/Son/Daughter/Grandparent

Don't know