Standardized Tool for the Assessment of Bruxism

STAB

Full Instrument

Index

Standardized Tool for the Assessment of Bruxism (STAB)

Basic Information Questionnaire

Sex

Male

Female

Unspecified/Other

Age **Height** **Weight**

_____ _____ _____

What's your current marital status?

Married

Living Together as Married

Divorced

Separated

Widowed

Never Married

What's your highest diploma or level of school that you have completed?

Compulsory education (<16 yrs)

18 Secondary School (such as high school) to 18 yrs

University or dropout (no degree)

University Graduate

Post-graduate Level

Axis A-Assessment of Bruxism Status and Consequences

（SBA）Subject Based Assessment (SBA)

Self Report

A1. Sleep Bruxism Report

A1.1 Sleep Bruxism Question

How often do you clench or grind your teeth during sleep on the last month (based on what you know)?

No
Less than 1 night/month
1-3 nights/month
1-3 nights/week
4-7 nights/week
Don't know

A1.1.1 Sleep Bruxism History Question

Did you use to clench or grind your teeth when asleep in the past, based on any information you have?

No
Yes
Don't know

A2. Awake Bruxism Report

A2.1 Awake Bruxism Question

How often did you grind your tooth when you're awake on the last month?

Never
A little of the time
Sometime
Most of the time
Always
Don't know

A2.1.1 Awake Bruxism History Question

Did you use to grind your tooth while you're awake in the past?

No
Yes
Don't know

A2.2 Awake Clenching Question

How often did you clench your tooth when you're awake on the last month?

Never
A little of the time
Sometime
Most of the time
Always
Don't know

A2.2.1 Awake Clenching History Question

Did you use to clench your tooth while you're awake in the past?

No
Yes
Don't know

A2.3 Awake tooth contact question

How often did you press, contact, or hold your tooth together (contact the uppe r and lower teeth) when you're not eating on the last month?

Never
A little of the time
Sometime
Most of the time
Always
Don't know

A2.3.1 Awake tooth contact history question

Did you use to press, contact, or hold your tooth together (contact the upper and lower teeth) when you're not eating in the past?

No

Yes

Don't know

A2.4 Awake jaw stress question

How often did you fix, tighten, or hold the muscle when you're not clenching or hold the upper and lower tooth on the last month?

Never

A little of the time

Sometime

Most of the time

Always

Don't know

A2.4.1 Awake jaw stress history question

Did you use to fix, tighten, or hold the muscle when you're not clenching or hold the upper and lower tooth together in the past?

No

Yes

Don't know

A3. Patient's Complaints

Temporojaw Disorders

A3.1 TMD pain

In the last 30 days, how long did your pain last in the jaw or temple site on either side?

No pain
Intermittent pain
Persistent pain

A3.2 Pain or stiffness while awake

In the last 30 days, did your jaw feel pain or stiffness on awakening?

No
Yes

A3.3 Joint locking

In the last 30 days, did you used to experience jaw locking or stucking (including short locking or stucking), that the jaw cannot open fully?

No
Yes

A3.4 Pain changes with jaw movement

In the last 30 days, did the following activities change (aka attentuate or exacerbate) the pain in the jaw or temple site on either side?

Chewing hard or tough food
Open mouth, or move the jaw forward or to the side
Habitual jaw movements (e.g., holding upper and lower teeth together, clenching teeth, grinding teeth, or chewing gum)
Other jaw activities, such as talking, kissing, or yawning

A3.5 Jaw joint noise

In the last 30 days, did you hear any jaw joint noise when you move or use your jaw?

No
Yes

A3.6 Muscle pain while awake

In the last 30 days, did you have jaw muscle pain during the following period?

Between waking up and breakfast
Between breakfast and lunch
Between lunch and dinner
Between dinner and bedtime

A3.6.1 Awake muscle tiredness or fatigue

In the last 30 days, did you have jaw muscle stiffness or sensitivity or tiredness or fatigue during the following period?

Between waking up and breakfast

Between breakfast and lunch

Between lunch and dinner

Between dinner and bedtime

A3.7 Awake symptom question

Do you have the following symptoms while awake?

Sensation of fatigue or pain or stress of jaw

Feeling of tooth clenching or lip pain

Pain in temple area

Feeling of tension in jaw joint, and need to move the jaw to release the tension

Difficulty to open mouth widely while awake

Hearning clicking sounds in jaw joint and consequently disappear while awake

Headache

A3.8 Headache

In the last 30 days, did you have headache in your temple area?

No

Yes

If yes, how many days?

Tooth wear

A3.9 Tooth wear

Do you have the following symptoms due to tooth wear?

Sensitivity and/or pain

Functional problems (difficulties chewing and eating)

Esthetic problems (Decreased attraction due to inesthetic tooth)

Broken or deterioration of dental hard tissue or restoration

Phonetic impairment

Tinnitus

A3.10 Tinnitus

Do you have noise or ringing in your ears (tinnitus)?

No

Yes

Xerostomia and drooling

A3.11 Xerostomia

Do you feel your mouth dry?

Never

Occasionally

Often

A3.12 Drooling

Do you feel drooling at night?

I never drool at night

My pillow gets wet sometimes at night

My pillow regularly gets wet at night

My pillow always gets wet at night

My pillow and sheet get wet every night

Clinically based assessment

Examination Report (For examiner's use)

A4. Joint and muscle
A4.1 Diagnosis of TMD (optional)
Mark the presence of the following diagnoses

A4.1.1. Pain disorders
*Complete this part only when the patient chose positive in item A3.3 (TMD pain screening)
Myalgia
Myofascial pain with spreading
Myofascial pain with referral
Right arthralgia
Left arthralgia
Headache due to TMD

A4.1.2. Right temporojaw disorders*
*Please specify if the diagnosis is based upon clinical or imaging evaluation
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 temporojaw disorders*
*Please indicate whether the diagnosis is based on clinical or imaging evaluation
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 hypertrophy
Please mark the site of masseter hypertrophy
left
right

A5. Intraoral and extraoral tissues

A5.1 Soft and bone tissue

Please record the following symptoms

Linea alba Left Right

Lip impression Upper Lower

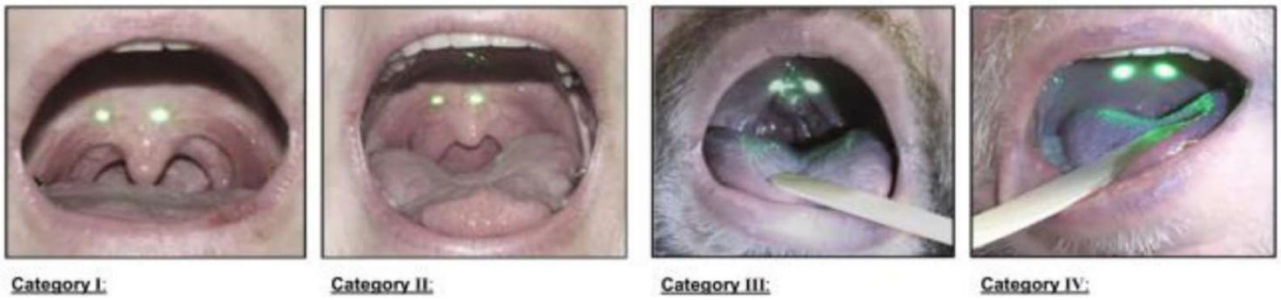
Tongue scalloping Right Front Left

Tongue ulceration* Right Front Left

Alveolar bone exostosis Mandible(buccal/lingual) Maxilla(buccal/lingual/midpalatal)

*If the texture is hard and tough-nodular with rolling border - urgent warning for further investigation

A5.2 Modified Friedman Grading



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

Category II: During phonation: visible uvula and palatal arch

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

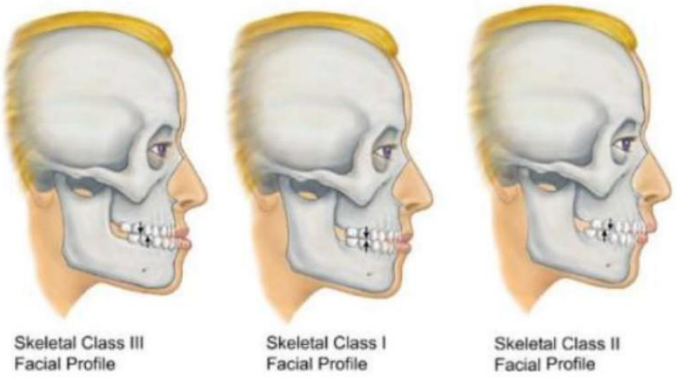
Category IV: During phonation or with tongue depressor: invisible uvula and palatal arch

A5.3 Skeletal Face Classification (Optional)

Class I

Class II

Class III

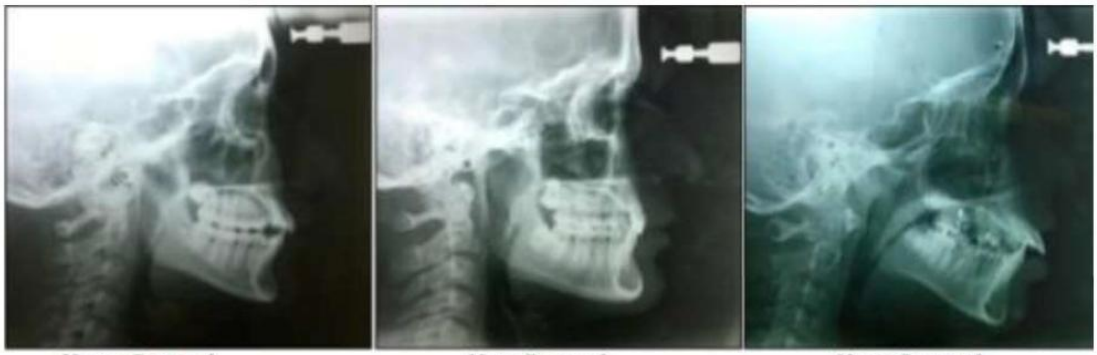


A5.4 Lateral Cephalogram (Optional)

Normal profile (medlium gonial angle)

Hypodivergent profile (low gonial angle)

Hyperdivergent profile (high gonial angle)



Normodivergent Hypodivergent Hyperdivergent

A6. Tooth and restorations

A6.1 Screener for tooth wear -- quantitative examination

Mark the highest score per sextant

	Sextant1	Sextant2	Sextant3	Sextant4	Sextant5	Sextant6
Occlusal/Incisal						
Palatal						

A.6.1.1 Identification of tooth wear

*When the quantitative score is deteceted ⩾2, identification is required.

Clinical symptoms indicate the influence of mechanical factors:

Shining, flat, and smooth tooth facets
Enamel and dentin wear at the same rate
Occlusal surface wear that matches the wear characteristics of the opposing teeth
Fracture of cusps or restorations
Impression in cheek mucosa, tongue, and lips
Located on the cervical region of the teeth, Non-Carious Cervical Lesions (NCCL)
Buccal or cervical lesions where the width of the defect is greater than the depth, Non-Carious Cervical Lesions (NCCL)
Cervical areas of premolars and cuspids are influenced
Cracks in the enamel
Torus mandibular

A6.2 Periodontal and dental examination

Mark the number of tooth with the following symptoms

	Sextant1	Sextant2	Sextant3	Sextant4	Sextant5	Sextant6
Mobility						
Heat sensitivity						
Discomfortness or pain in biting						
Tooth fracture						

A6.3 Restorations

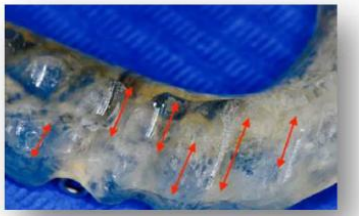
Mark the number of tooth/implants with the following symptoms

	Sextant1	Sextant2	Sextant3	Sextant4	Sextant5	Sextant6
Dental filling lost/defect						
Restoration cracks						

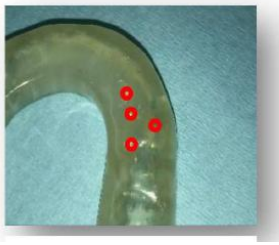
Ceramic fractures						
Implant mobility						
Implant fracture						
Implant screw loosening						

A6.4 Oral appliance evaluation (if the patient used hard resin splints)
Mark the following signs:

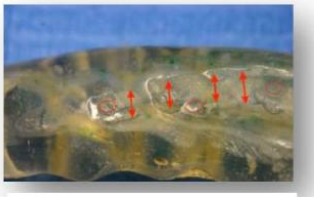
Widespread grinding marks (aka strips) right front left
Widespread clenching marks (circular points) right front left
Coexistence of grinding and clenching marks right front left
fractures or perforations right front left



Example of grinding marks



Example of clenching marks



Example of combined marks

Instrument based assessment (IBA)

Technical report

A7. Sleep Bruxism

A7.1 Electromyography

Number of mastocatory muscle event 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)

Scoring the grinding noise via smartphone application

A7.4 Pressure sensor (Optional)

Number of the biting events

A8. Awake bruxism

A8.1 Ecological transient evaluation -- week report

Condition	in one week (%)	in a few weeks (%)
relaxed jaw muscle (no tooth contact)		
jaw bracing (no tooth contact)		
tooth contact (light and stable contact)		
tooth clenching (strong and stable contact)		
tooth grinding		

A8.2 Awake Electromyography

Number of masticatory muscle events over 10% MVC
Bruxism time index
Bruxism work index

A8.3 Other methods: to be determined

A9. Other devices

A9.1. Oral acidity (optional)

Rest salivary pH
Rest salivary flow
Stimulated salivary pH (chewing paraffin)
Stimulated salivary flow

Axis B-Risk factors and Etiological factors and Comorbid conditions

B1. Psychosocial assessment

Self report

B1.1 Screening of anxiety and depression

In the last 2 weeks, how did the following questions bother you?

1. Feeling stressed, anxious or discomfort
Not at all
Several days
More than half the days
almost everyday

2. Unstoppable or uncontrollable worrying
Not at all
Several days
More than half the days
almost everyday

3. No interest or pleasure to do things
Not at all
Several days
More than half the days
almost everyday

4. feeling down, depressed or hopeless
Not at all
Several days
More than half the days
almost everyday

B1.2 Coping

Consider the matching degree of following statements with your behavior or activity

1. I seek for creative ways to overcome difficulty
not match
not too match
basically match
relatively match
totally match

2. No matter what happened, I believe I can control my reaction
not match
not too match
basically match
relatively match
totally match

3. I believe I can continually grow up via positively overcome difficulty
not match
not too match
basically match
relatively match
totally match

4. I will positively seek for ways to make up for loss in life
not match
not too match
basically match
relatively match
totally match

B2 Concurrent sleep-related state assessment

Self report

B2.1 Sleep Apnea Syndrome Screening

Please mark the following question with answer "yes"

Do you snore loudly?

Do you often feel tiredness, fatigue or sleepy?

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

Do you have or currently being treated for high blood pressue?

Is your BMI higher than 35?

Is your age older than 50 yrs?

Is your neck size large (male > 43cm, female >41cm)

Sex=male?

B2.2 Insomnia Screening

Indicate which of the following statements describe you

I have difficuly falling asleep

Too many thoughts to get sleep

I usually have sleep problems a couple times a week

I have trouble falling asleep after waking up

I worry about things and have trouble relaxing

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

I lie awake for half an hour or longer before falling asleep

B2.3 Periodic limb movement disorders and restless legs syndrome screening

Indicate which of the following statements describe you

When I don't work out, my legs still feel muscle tension

I've noticed (or been told) that a part of my body twitches in my sleep

I've been told I kick the covers off at night

My legs always feel sore or antsy when I try to sleep

I get pain or cramps in my legs at night

Sometimes my leg won't stay still and I have to move it to make myself comfortable

Even though I sleep at night, I am still sleepy during the day

B2.4 Oral behavior-Sleep position

In the last month, how often does your sleep position put pressure on your chi n?

Never

Few times

Sometimes

Most times

Always

Don’t know

B3. Contemporaneous non-sleep state assessment

Self-report

B3.1 oral behaviors-activities during awake time

In the past of a month, what's the frequency of activities as below?

Q7. Extend or rest the lower jaw forward or to the side
never
seldom
sometimes
most part of time
always
unknown

Q8. Push your tongue against your teeth.
never
seldom
sometimes
most of the time
always
unknown

Q9. Put your tongue between the teeth.
never
seldom
sometimes
most of the time
always
unknown

Q10. Biting, chewing, or playing with the tongue, cheeks, or lips
never
seldom
sometimes
most of the time
always
unknown

Q11. Hold jaw in a rigid or tense position, such as bracing or guarding it
never
seldom
sometimes

most of the time
always
unknown

Q12. Holding or biting objects with teeth, such as hair, pipes, pencils, pens, fingers, fingernails, etc.
never
seldom
sometimes
most of the time
always
unknown

Q13. chewing gums
never
seldom
sometimes
most of the time
always
unknown

Q14. Play instruments that need the mouth or jaw
never
seldom
sometimes
most of the time
always
unknown

Q15. Leaning on the jaw with the hand, e.g., resting or supporting the chin with the hand
never
seldom
sometimes
most of the time
always
unknown

Q16. chewing food on one side
never
seldom
sometimes
most of the time
always

unknown

Q17. Eat between meals
never
seldom
sometimes
most of the time
always
unknown

Q18. Keep talking (e.g. lectures, sales, customer service)
never
seldom
sometimes
most of the time
always
unknown

Q19. singing
never
seldom
sometimes
most of the time
always
unknown

Q20. yawn
never
seldom
sometimes
most of the time
always
unknown

Q21. Put the phone between your head and shoulder
never
seldom
sometimes
most of the time
always
unknown

B3.2 smartphone use(Optional item)
Indicate the average time of smartphone use/day

B3.3 Oral-facial movement disorder

Have you been diagnosed with any of the following diseases or have related sy mptoms?

Oromaxillofacial movement disorders
Mandibular dystonia
Parkinson's disease
Huntington's disease
Tourette's syndrome
hemifacial spasm
Tardive dyskinesia

B3.4 Gastroesophageal Reflux Disease Screening

How many times a week do you experience the following symptoms?

A. Burning sensation behind the sternum (heartburn)
0day
1day
2-3days
4-7days

B. Stomach contents moving up to throat or oral cavity (reflux)
0day
1day
2-3days
4-7days

C. Middle and upper abdomen pain
0day
1day
2-3days
4-7days

D. be sick
0day
1day
2-3days
4-7days

E. unable to sleep well due to heartburn and reflux
0day
1day
2-3days
4-7days

F. heartburn and reflux that require OTC drugs to treat
0day
1day
2-3days
4-7days

B3.5 Autoimmune disease and connective tissue disease screening
Have you been diagnosed with any of the following diseases ?
Rheumatoid arthritis
lupus
other systemic rheumatic disease, such as fibromyalgia
other systemic disease,such as systemic sclerosis, polymyalgia rheumatica, mixed connective tissue disease

B3.6 attention defective and hyperactivity disorder
Have you been diagnosed with ADHD?
NO
YES

B4. Assessment for prescribed medications and use of other drugs

Self report

B4.1 Drugs

Please record whether you use recreational or street drugs

f yes, please explain what kind of drugs you use for recreation?

B4.2 Medications

Are you current on the following medications?

Anti-depressants (eg selecetive serotonin-reuptake inhibitor)

benzodiazepins

Antipsychotics, antiemetics (dopamine antagonists)

ADHD medication

Antiallergic medication

CBD medical marijuana CBD

TSH medical marijuana TSG

Opioids

Other

If yes, please list all medications and doses

B4.3 Tobacco

Do you smoke or use any tobacco products?

No

Yes

Ceased

If yes, how many cigarettes/day do you smoke?

B4.4 Alcohol

Did you drink alcoholic drinks (beer, wine, hard liquor)?

No

Yes

Ceased

If yes, how many cup/day do you drink?

B4.5 Soft drinks

Do you often drink soft drinks (Cola/RedBull/Spirites/FANTA)?

No

Yes

Ceased

If yes, how many cup/day do you drink?

B4.6 Juice and fruits

Do you often drink juice or citric fruits (eg lemon, orange, grapefruit)?

No

Yes

Ceased

If yes, how many cup/day do you drink?

B4.7 Caffeinate

Do you often drink coffee, tea or other drinks containing caffeine?

No

Yes

Ceased

If yes, how many cup/day do you drink?

B5. Assessment for other factors

B5.1 Bruxism Family History Screening

Do you know your family members (eg, father, mother, children) have bruxism history?

No

Yes Father/mother/son/daughter/grandfather/grandmother

Don't know

B5.2 Tooth wear Family History Screening

Do you know your family members (eg, father, mother, children) have tooth wear?

No

Yes Father/mother/son/daughter/grandfather/grandmother

Don't know

B5.3 Sleep Apnea Syndrome Family History Screening

Do you know your family members (eg, father, mother, children) have Sleep Apnea Syndrome?

No

Yes Father/mother/son/daughter/grandfather/grandmother

Don't know

B5.4 Orofacial pain Family History Screening

Do you know your family members (eg, father, mother, children) have orofacial pain?

No

Yes Father/mother/son/daughter/grandfather/grandmother

Don't know

B5.5 Gastroesophageal Reflux Disease Family History Screening

Do you know your family members (eg, father, mother, children) have gastroesophageal reflux diseases?

No

Yes Father/mother/son/daughter/grandfather/grandmother

Don't know