

**Standardized Tool for the Assessment of
Bruxism
STAB**

Full Instrument

Index of contents

Basic Information Questionnaire

Axis A- Assessment of Bruxism Status and Consequences

Subject-Based Assessment (SBA) - Self-Report

- A1. Sleep Bruxism report
- A2. Awake Bruxism report
- A3. Patient's complaints

Clinically Based Assessment (CBA) - Examiner's Report

- A4. Joints and muscles
- A5. Intraoral and extraoral tissues
- A6. teeth and restorations

Instrument-based assessment (IBA) - Technology report

- A7. Sleep Bruxism
- A8. Awake Bruxism
- A9. Additional instruments

Axis B - Risk and Etiological factors and co-morbid Conditions

- B1. Psychosocial assessment
- B2. concurrent Sleep-related Conditions Assessment
- B3. Concurrent Non-Sleep Conditions Assessment
- B4. Prescribed Medications and Use of Substances Assessment
- B5. Other Factors Assessment

Standardized Tool for Assessment of Bruxism (STAB)

Basic Information Questionnaire

Sex:

Male

Female

Unspecified/Other

Age

Height

Weight

What is your current marital status?

Married

Living as married

Divorced

Separated

Widowed

Never Married

What is the highest grade or level of schooling that you have completed?

Compulsory school (<16 years old)

Secondary school (e.g. high school) up to 18 years

Some University (no degree)

University graduate

Post-Graduate level

Axis A-Assessment of Bruxism Status and Consequences

Subject Based Assessment (SBA)

Self Report

A1. Sleep Bruxism report

A1.1 Sleep Bruxism Question

How often do you clench or grind your teeth when asleep based on the last month (based on any information you may have)?

None of the time

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

Based on any information you have, did you use to clench or grind your tooth during sleep in the past?

No

Yes

Don't know

A2. Awake Bruxism Report

A2.1 Awake Teeth Grinding Questions

How often did you grind your teeth together during waking hours based on the the last month?

- None of the time
- A little of the time
- Some of the time
- Most of the time
- All of the time
- Don't know

A2.1.1 Awake Teeth Grinding History Question

Did you use to grind your tooth together during waking hours in the past?

- No
- Yes
- Don't know

A2.2 Awake Teeth Clenching Question

How often did you clench your teeth together during waking hours,based on the last month?

- None of the time
- A little of the time
- Some of the time
- Most of the time
- All of the time
- Don't know

A2.2.1 Awake Teeth Clenching History Question

Did you use to clench your teeth together during waking hours in the past?

- No
- Yes
- Don't know

A2.3 Awake Teeth Contact Question

How often did you press, touch, or hold your teeth together (the contact between upper and lower teeth) when not eating based on the last month?

- None of the time
- A little of the time
- Some of the time
- Most of the time
- All of the time
- Don't know

A2.3.1 Awake Teeth Contact History Question

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

No

Yes

Don't know

A2.4 Awake Tightened Mandible Question

How often did you hold, tighten or tense your muscles without clenching or bring teeth together, based on the last month?

None of the time

A little of the time

Some of the time

Most of the time

All of the time

Don't know

A2.4.1 Awake Tightened Mandible History Question

Did you use to hold, tighten, or tense your muscles without clenching or bringing teeth together in the past?

No

Yes

Don't know

A3. Patient's complaints

Temporomandibular Disorders

A3.1 TMD Pain

How long did the pain in your jaw or temple area on either side last in the last 30 days?

No pain

Pain comes and goes

Pain is present all the time

A3.2 Pain or Stiffness on Awakening

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

No

Yes

A3.3 Joint Lock

In the last 30 days, have your jaw locked or stuck (even for a moment), so it would not fully open?

No

Yes

A3.4 Pain Changes with Jaw Movements

In the last 30 days, did the following activities change the pain (i.e., relieve or exacerbate) in the jaw or temple on either side?

Chewing hard or tough foods

Opening your mouth, or moving your 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 Noises

In the last 30 days, have you had any jaw joint noises when you moved or used your jaw?

No

Yes

A3.6 Waketime Muscle Pain

In the last 30 days, did you have the pain in the jaw muscles during any of the following times of the day?

Between waking up and breakfast

Between breakfast and lunch

Between lunch and dinner

Between dinner and bedtime

A3.6.1 Waketime Muscle Tiredness or Fatigue

In the past 30 days, did you have stiffness, sensitivity, tiredness, or fatigue of the jaw muscles during any of the following times in the day?

Between waking up and breakfast

Between breakfast and lunch

Between lunch and dinner

Between dinner and bedtime

A3.7 Awakening Symptoms Question

Do you experience any of the following symptoms on awakening?

Feeling of fatigue or pain or tension in the jaws

Feeling that your teeth are clenched or your lips are painful

Pain in the temples

Feeling tension in the jaw joint on awakening so that you have to move the jaw to release the tension

Difficulty opening your mouth wide on awakening

Hearing a click in the jaw joint on awakening that disappear afterwards

Headache

A3.8 Headache

In the past 30 days, have you had any headache that included the temple areas of your head?

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 in chewing and eating)

Aesthetic issues (less attractive due to the teeth appearance)

Damage of dental hard tissue and restorations

Phonetic impairment

Tinnitus

A3.10 Tinnitus

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

No

Yes

Xerostomia and Drooling

A3.11 Xerostomia

Does your mouth feel dry?

Never

Occasionally

Often

A3.12 Drooling

Do you feel that you drool at night?

I don't drool at night

My pillow sometimes gets wet at night

My pillow regularly gets wet at night

My pillow always gets wet at night

My pillows and sheets get wet every night

Clinically Based Assessment (CBA)

Examiner's Report (For Examiner's Use)

A4. Joints and muscles

A4.1 Diagnosis of TMD (optional item)

Mark the presence of the following diagnoses

A4.1.1. Pain Disorders*.

*Fill this section only if item A3.3 (TMD Pain Screening) is positively confirmed by the patient

Myalgia

Myofascial pain with spreading

Myofascial pain with referral

Right arthralgia

Left arthralgia

Headache due to TMD

A4.1.2. Right TMJ Disorder*

*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 TMJ Disorder*

*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 Muscle Hypertrophy

Please mark the presence of masseter hypertrophy

left

right

A5. Intraoral and extraoral tissues

A5.1 Soft and Bone Tissues

Please make the presence of the following signs:

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/mid palatal)

*If positive for firm , indurated, and rolled borders - a warning for further urgent examination

A5.2 Modified Friedman Grading



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

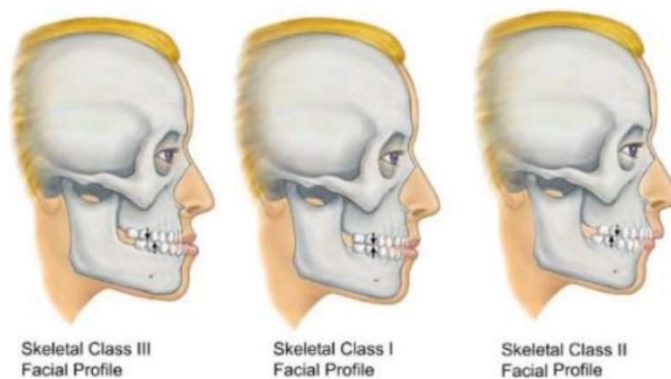
Category IV: with phonation,/tongue depressor, uvula and palatal arch not visible

A5.3 Skeletal Class(Optional Item)

Class I

Class II

Class III



A5.4 Skeletal Profile(Optional Item)

Normodivergent profile (medium gonial angle)

Hypodivergent profile (low gonial angle)

Hyperdivergent profile (high gonial angle)



A6. Teeth and Restorations

A6.1 Screening for Tooth Wear - Quantitative Examination

Indicate the highest score for tooth wear per sextant

	Sextant1	Sextant2	Sextant3	Sextant4	Sextant5	Sextant6
Occlusal/Incisal						
Palatal						

A.6.1.1 Tooth Wear Qualification*

*Qualification is required when a quantitative score of ≥ 2 is detected.

Clinical signs indicating the presence 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

Indicate the number of teeth labeled with the following signs

	Sextant1	Sextant2	Sextant3	Sextant4	Sextant5	Sextant6
Mobility						
Thermal Sensitivity						
Discomfort/pain on biting						
Fractured teeth						

A6.3 Restorations

Indicate the number of teeth/implants with the following signs

	Sextant1	Sextant2	Sextant3	Sextant4	Sextant5	Sextant6
Lost/broken fillings						
Cracks in restorations						

Ceramic fractures						
Mobile implant						
Implant fractures						
Implant screw loosening						

A6.4 Oral appliance evaluation(if hard resin splint is used by the patient)

Mark the presence of the following signs:

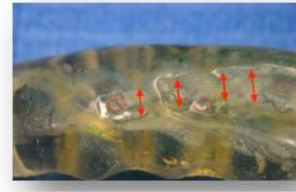
Prevalence of grinding marks (i.e., strips)	Right	Front	Left
Prevalence of clenching marks (i.e., circle-shaped dots)	Right	Front	Left
Combination of grinding and clenching marks	Right	Front	Left
Fractures or perforations	Right	Front	Left



Example of grinding marks



Example of clenching marks



Example of combined marks

Instrument-Based Assessment (IBA)

Technology Report

A7. Sleep Bruxism

A7.1 Electromyography

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)

Score teeth grinding sounds via smartphone application

A7.4 Pressure Sensor (optional)

Number of events of bite pressure

A8. Awake Bruxism

A8.1 Ecological momentary Assessment - one week report

Condition	Week 1 (%)	additional weeks (%)
Relaxed jaw muscles (no teeth contact)		
Tightened jaw muscles (no teeth contact)		
Teeth contact (light and steady contact)		
Teeth clenching (strong and steady contact)		
Teeth grinding		

A8.2 Waketime Electromyography

Number of masseter events exceeding 10% MVC

Bruxism time index

Bruxism work index

A8.3 Other Methods: To be determined

A9. Additional instruments

A9.1. Intraoral Acidity (optional)

Rest salivary PH

Rest salivary flow

Stimulated salivary PH (paraffin)

Stimulated salivary flow

Axis B - Risk, Etiologic Factors and Comorbid Conditions

B1. Psychosocial Assessment

Self-Report

B1.1 Anxiety and Depression Screening

In the last two weeks, how often have you been bothered by the following problems?

1. Feeling nervous, anxious or on edge

Not at all

For a few days

More than half the time

Nearly every day

2. Not being able to stop or control worrying

Not at all

A few days

More than half the time

Nearly every day

3. Little interest or pleasure in doing things

Not at all

A few days

More than half the time

Nearly every day

4. Feeling down, depressed, or hopeless

Not at all

A few days

More than half the time

Nearly every day

B1.2 Coping

Consider how well the following statements describe your behaviors and actions

1. I look for creative ways to solve problems

Does not describe me at all

Does not describe me

Neutral

Describes me

Describes me perfectly

2. I believe I can control my reactions no matter what happens

Does not describe me at all

Does not describe me

Neutral

Describes me

Describes me perfectly

3. I believe I can grow by positively dealing with difficulties

Does not describe me at all

Does not describe me

Neutral

Describes me

Describes me perfectly

4. I will actively look for ways to make up for the losses I have encountered in my life

Does not describe me at all

Does not describe me

Neutral

Describes me

Describes me perfectly

B2. Concurrent sleep-related conditions assessment

Self-Report

B2.1 Sleep Apnea Syndrome Screening

Please mark the following questions with a positive answer

Do you snore loudly?

Do you often feel tired, fatigued and sleepy during the day?

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

Do you have or are you being treated for high blood pressure?

Do you have a BMI more than 35?

Are you older than 50 years old?

Neck size large (>43cm for men; >41cm for women)

Gender = male?

B2.2 Insomnia Screening

Indicate which of the following statements can be applied to you

I have difficulty falling asleep

I have a lot of thoughts and have trouble falling asleep

I usually have problems with sleep a few times a week

I wake up and cannot go back to sleep

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 more before falling asleep

B2.3 Periodic Limb Movement Disorder and Restless Legs Syndrome Screening

Indicate which of the following statements can be applied to you

I still feel muscle tension in my legs when not exercising

I notice (or have been told) that a part of my body twitches during sleep

I have been told that I kick at night

My legs always feel sore or aching when I try to go to sleep

I experience 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

Despite sleeping at night, I am still sleepy during the day

B2.4 Oral Behavior- Sleeping Position

In the past month, how often did your sleeping position cause pressure on your jaw?

None of the time

A little of the time

Some of the time

Most of the time

All of the time

Don't know

B3. Concurrent Non-Sleep Conditions Assessment

Self-Report

B3.1 Oral Behavior - Activities on Awakening

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

Q7.Hold or jut jaw forward or to the side

None of the time

A little of the time

Some of the time

Most of the time

All of the time

Don't know

Q8.Press tongue forcibly against teeth

None of the time

A little of the time

Some of the time

Most of the time

All of the time

Don't know

Q9.Place tongue between teeth

None of the time

A little of the time

Some of the time

Most of the time

All of the time

Don't know

Q10.Bite,chew or play with your tongue,cheeks or lips

None of the time

A little of the time

Some of the time

Most of the time

All of the time

Don't know

Q11.Hold jaw in rigid or tense position,such as to brace or protect the jaw

None of the time

A little of the time

Some of the time

Most of the time
All of the time
Don't know

Q12. Hold between the teeth or bite objects such as hair, pipe, pencil, pens, fingers, fingernails etc

None of the time
A little of the time
Some of the time
Most of the time
All of the time
Don't know

Q13. Use chewing gum

None of the time
A little of the time
Some of the time
Most of the time
All of the time
Don't know

Q14. Play musical instrument that involves use of mouth or jaw

None of the time
A little of the time
Some of the time
Most of the time
All of the time
Don't know

Q15. Lean with your hand on the jaw, such as cupping or resting the chin in the hand

None of the time
A little of the time
Some of the time
Most of the time
All of the time
Don't know

Q16. Chew food on one side only

None of the time
A little of the time
Some of the time
Most of the time
All of the time
Don't know

Q17.Eating between meals

None of the time

A little of the time

Some of the time

Most of the time

All of the time

Don't know

Q18.Sustained talking(e.g.,teaching,sales,customer services)

None of the time

A little of the time

Some of the time

Most of the time

All of the time

Don't know

Q19.Singing

None of the time

A little of the time

Some of the time

Most of the time

All of the time

Don't know

Q20.Yawning

None of the time

A little of the time

Some of the time

Most of the time

All of the time

Don't know

Q21.Hold telephone between your head and shoulders

None of the time

A little of the time

Some of the time

Most of the time

All of the time

Don't know

B3.2 Smartphone Use (optional item)

Indicate the average time/day of smartphone use

B3.3 Orofacial Motor Disorders

Have you been diagnosed with or do you have symptoms associated with any of the following conditions?

Orofacial Dyskinesia
Mandibular Dystonia
Parkinson's Disease
Huntington's Disease
Tourette's Syndrome
Facial muscle spasms
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)

0 Days
1 Day
2-3 Days
4-7 Days

B. Stomach contents moving upward to the throat or mouth (regurgitation)

0 Days
1 Day
2-3 Days
4-7 Days

C. Pain in the middle or upper abdomen

0 Days
1 Day
2-3 Days
4-7 Days

D. Nausea

0 Days
1 Day
2-3 Days
4-7 Days

E. Difficulty getting a good sleep due to heartburn and regurgitation

0 Days
1 Day
2-3 Days
4-7 Days

F. Need for over-the-counter medications for heartburn and regurgitation

0 Days

1 Day

2-3 Days

4-7 Days

B3.5 Autoimmune or Connective Tissue Diseases Screen

Have you been diagnosed with one of the following diseases?

Rheumatoid Arthritis

Lupus

Other systemic rheumatic diseases, including fibromyalgia

Other systemic disease, 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?

No

Yes

B4. Assessment of Prescription and Other Medicine

Self Report

B4.1 Drugs

Mark if you use recreational or street drugs

If yes, please state which drugs you use for recreational purposes _____

B4.2 Medications

Are you currently under one of the following medications?

Antidepressants (e.g., selective serotonin reuptake inhibitors)

Benzodiazepines

Neuroleptics Antipsychotics, antiemetics (dopamine antagonists)

ADHD medication

Anti-allergy medication

Medical marijuana CBD

Medical marijuana TSH

Opioids

Other

If yes, please list all medications and dosages

B4.3 Tobacco

Do you smoke or use any tobacco products?

No

Yes

Quit

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

B4.4 Alcohol

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

No

No

Quit

If yes, what is your approximate intake of the alcoholic beverages(glasses/day)? _____

B4.5 Soft Drinks

Do you regularly drink soft drinks (e.g. Coke/Red Bull/Sprite/Fenta, etc.)?

No

Yes

Quit

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

B4.6 Juices and Fruits

Do you regularly drink juices or citrus fruits (e.g. lemons, oranges, 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. Assessment of Other Factors

B5.1 Screening for Family History of Bruxism

Do you know anyone in your family (e.g., father, mother, child) who has had a history of bruxism?

No

Yes Father/Mother/Son/Daughter/Grandfather/Grandmother

Don't know

B5.2 Screening for Family History of Tooth Wear

Do you know anyone in your family (e.g., father, mother, child) who has had a history of tooth wear?

No

Yes Father/Mother/Son/Daughter/Grandfather/Grandmother

Don't know

B5.3 Screening for Family History of Sleep Apnea Syndrome

Do you know anyone in your family (e.g., father, mother, child) who has had sleep apnea syndrome?

No

Yes Father/Mother/Son/Daughter/Grandfather/Grandmother

Don't know

B5.4 Screening for Family History of Orofacial Pain

Do you know of anyone in your family (e.g., father, mother, child) who has had orofacial pain?

No

Yes Father/Mother/Son/Daughter/Grandfather/Grandmother

Don't know

B5.5 Screening for Family History of Gerd

Do you know anyone in your family (e.g., father, mother, child) who has had gastroesophageal reflux disease?

No

Yes Father/Mother/Son/Daughter/Grandfather/Grandmother

Don't know