Standardized Tool for the Assessment of Bruxism (STAB)

Demographic Questionnaire

Gender
☐ 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 level of education you have completed?
☐ Compulsory education (<14 years)
☐ Secondary school (e.g., high school) up to 18 years
☐ Some university education (no degree)
☐ University graduate
☐ Postgraduate level

Self-Reported Assessment (SRA) - Sleep Bruxism Report (SBR)

A1.1.1 Sleep Bruxism History Question

In the past (based on any information available to you), have you clenched or ground your teeth while asleep?

☐ No
☐ Yes
☐ Don't know

A2. Awake Bruxism Report

A2.1 Awake Teeth Grinding Question

Based on the past month, how often have you ground your teeth while awake?

☐ Never
☐ For a little while
☐ For some time
☐ Most of the time
☐ All the time
☐ Don't know

A2.1.1 Awake Teeth Grinding History Question

In the past, have you ground your teeth while awake?

☐ No
☐ Yes
☐ Don't know

A2.2 Awake Teeth Clenching Question

Based on the past month, how often have you clenched your teeth while awake?

☐ Never
☐ For a little while
☐ For some time
☐ Most of the time
☐ All the time
☐ Don't know

A2.2.1 Awake Teeth Clenching History Question
In the past, have you clenched your teeth while awake?

☐ No
☐ Yes
☐ Don't know

A2.3 Awake Teeth Contact Question
Based on the past month, how often have you pressed, touched, or held your teeth together (upper and lower teeth contact) other than while eating?

☐ Never
☐ For a little while
☐ For some time
☐ Most of the time
☐ All the time
☐ Don't know

A2.3.1 Awake Teeth Contact History Question

In the past, have you pressed, touched, or held your teeth together (upper and lower teeth contact) other than while eating?

☐ No
☐ Yes
☐ Don't know

A2.4 Awake Mandible Muscle Tension or Tightening Question

Based on the past month, how often have you held, tightened, or tensed your jaw muscles without clenching or contacting your teeth?

☐ Never
☐ Rarely
☐ Sometimes
☐ Most of the time
☐ All the time
☐ Don't know

A2.4.1 Awake Mandible Muscle Tension or Tightening History Question

In the past, have you held, tightened, or tensed your jaw muscles without clenching or contacting your teeth?

☐ No
☐ Yes
☐ Don’t know

A3. Patient’s Complaints

Temporomandibular Disorders (TMD)

A3.1 TMD Pain
In the last 30 days, how long have you experienced pain in your jaw or temple area (on either side)?

☐ No pain
☐ Pain comes and goes
☐ Pain is always present

A3.2 Pain or Stiffness Upon Awakening
In the last 30 days, have you experienced pain or stiffness in your jaw upon awakening?

☐ No
☐ Yes

A3.3 Jaw Locking
In the last 30 days, has your jaw locked or become stuck, even for a short moment, such that it could not open FULLY?

☐ No
☐ Yes

A3.4 Pain Change with Activities
In the last 30 days, did the following activities change any pain in your jaw or temple area (i.e., did they improve or worsen the pain)?

☐ Chewing hard or tough food
☐ Opening your mouth or moving your jaw forward or to the side
☐ Jaw habits (e.g., holding teeth together, clenching, grinding, chewing gum)
☐ Other jaw activities such as talking, kissing, or yawning

A3.5 Jaw Joint Noises
In the last 30 days, have you heard or felt any noise(s) coming from your jaw joint when moving?

☐ No
☐ Yes

A3.6 Daytime Muscle Pain
In the last 30 days, have you experienced pain in your jaw muscles during any of the following time periods?

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

A3.6.1 Daytime Muscle Fatigue or Stiffness
In the last 30 days, have you experienced stiffness, fatigue, or a sensation of tiredness in your jaw muscles? If yes, during which of the following time periods?

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

A3.7 Symptoms Upon Awakening
Do you experience any of the following symptoms upon awakening?

☐ A sensation of fatigue, pain, or tightness in your jaw
☐ Feeling that your teeth are clenched or that your mouth is sensitive
☐ Aching in your temple area
☐ A feeling of tension in your jaw joint upon awakening and a need to move your lower jaw to release it
☐ Difficulty in opening your mouth wide upon awakening
☐ Hearing or feeling a clicking sound in your jaw joint upon awakening that disappears afterward

A3.8 Headache
In the last 30 days, have you experienced any headache that included the temple area?

☐ No
☐ Yes

If "Yes," for how many days? : _____

A3.9 Tooth Wear
Do you experience any of the following symptoms due to your existing tooth wear?

☐ Sensitivity and/or pain
☐ Functional problems (difficulty chewing and eating)
☐ Deterioration of esthetic appearance (reduced attractiveness)
☐ Fracture, chipping, or crumbling of hard tissues and restorations
☐ Phonetic difficulties (trouble producing certain sounds)

A3.10 Tinnitus
Do you experience ringing or buzzing in your ears (tinnitus)?

☐ No
☐ Yes

Xerostomia and Drooling

A3.11 Xerostomia (Dry Mouth)
Do you feel dryness in your mouth?

☐ Never
☐ Occasionally
☐ Often

A3.12 Drooling
Do you drool saliva during the night?

☐ I do not drool at all during the night
☐ Some nights my pillow gets wet with saliva
☐ My pillow frequently gets wet with saliva during the night
☐ My pillow always gets wet with saliva during the night
☐ Every night, both my pillow and other bedclothes get wet with saliva

Clinical Assessment (CA)

Examination Report (FOR EXAMINER'S USE ONLY)

A4. Joints and Muscles

A4.1 TMD Diagnoses (Optional Item)

Mark the presence of the following diagnoses:

A4.1.1 Pain Disorders
Only complete this section if the patient has positively responded to A3.3 (TMD Pain Screener).
☐ Myalgia
☐ Myofascial pain with spreading
☐ Myofascial pain with referral
☐ Right arthralgia
☐ Left arthralgia
☐ Headache attributed to TMD

A4.1.2 Right TMJ Disorders
Please indicate if the diagnosis is based on clinical or imaging assessment.
☐ Disc displacement with reduction
☐ Disc displacement with reduction and 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 Disorders
Please indicate if the diagnosis is based on clinical or imaging assessment.
☐ Disc displacement with reduction
☐ Disc displacement with reduction and 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

Mark the presence of masseter hypertrophy:
☐ Left
☐ Right

A5. Intraoral and Extraoral Tissues

A5.1 Soft and Hard Tissues

Mark the presence of the following findings:

- **Linea alba** (buccal mucosal line):
  ☐ Left
  ☐ Right
- **Lip indentations**:
  ☐ Upper
  ☐ Lower
- **Scalloped tongue (tooth indentations)**:
  ☐ Right
  ☐ Front
  ☐ Left
- **Tongue ulceration***:
  ☐ Right
  ☐ Front
  ☐ Left
- **Alveolar bone exostoses**:
  ☐ Mandible (Buccal/Lingual)
  ☐ Maxilla (Buccal/Lingual/Midpalatal)

*Note: If tongue ulceration is positive and exhibits firm, indurated, or rolled borders, it should be considered a "red flag" requiring urgent further investigation.

A5.2 Modified Friedman Tongue Position

☐ Category I:

Without phonation (no "Ah" sound) / no tongue depressor used - Uvula and palatal arch are fully visible.

☐ Category II:

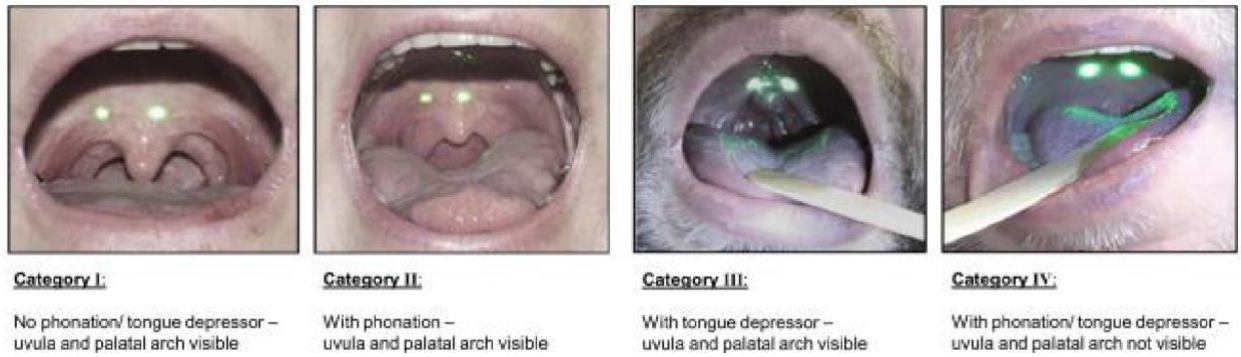
With phonation ("Ah" sound) - Uvula and palatal arch are visible.

☐ **Category III:**

With the use of a tongue depressor - Uvula and palatal arch are visible.

☐ **Category IV:**

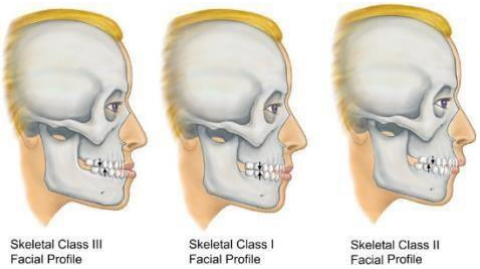
With phonation ("Ah" sound) and/or use of a tongue depressor - Uvula and palatal arch are not visible.



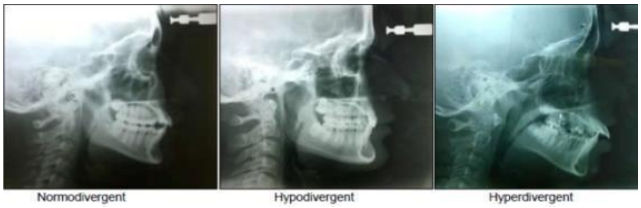
A5.3 Skeletal Class (Optional Item)

The evaluation of skeletal class involves the classification of the patient's skeletal relationships and is categorized as follows:

☐ **Class 1**
☐ **Class 2**
☐ **Class 3**



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 Tooth Wear Screening – Quantitative Assessment

Indicate the highest tooth wear score for each sextant.

	Sextant 1	Sextant 2	Sextant 3	Sextant 4	Sextant 5	Sextant 6
Occlusal/Incisal						
Palatal						

A6.1.1 Tooth Wear - Qualitative Assessment
Qualitative assessment is required when a score of ≥2 is detected during the quantitative assessment.

Clinical signs indicating the influence of mechanical factors:
☐ Shiny, flat, and glossy surfaces (shiny facets).
☐ Cases where enamel and dentin wear at the same rate.
☐ Occlusal surface wear with matching features on opposing teeth.
☐ Fractures of cusps or restorations.
☐ Impressions or marks on the cheek, tongue, and/or lips.
☐ Non-carious cervical lesions (NCCL) located in the cervical areas of teeth.
☐ Buccal/cervical lesions that are wider than they are deep (non-carious cervical lesions - NCCL).
☐ Affected cervical regions of premolars and canines.
☐ Cracks observed within the enamel.
☐ Mandibular tori (bony protrusions in the mandible).

A6.2 Periodontal and Dental Examination

Specify the number of teeth with the following signs for each respective sextant:

Sign	Sextant 1	Sextant 2	Sextant 3	Sextant 4	Sextant 5	Sextant 6
Mobility						
Thermal sensitivity						
Discomfort/pain on chewing						
Fractured teeth						

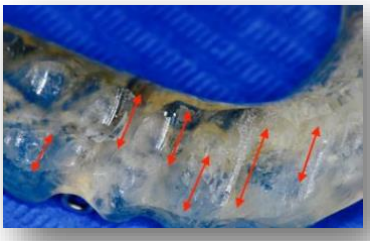
A6.3 Restorations

Specify the number of teeth/implants with the following signs:

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

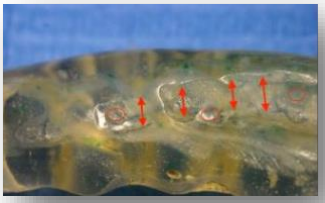
A6.4 Oral Appliance Evaluation

(*Applicable if the patient uses a hard acrylic resin splint*)



Example of grinding marks

Example of clenching



Example of combined marks.

Mark the presence of the following signs:

- **Prevalence of grinding marks** (e.g., deep lines/grooves):
  ☐ Right
  ☐ Front
  ☐ Left
- **Prevalence of clenching marks** (e.g., circular spots):
  ☐ Right
  ☐ Front
  ☐ Left
- **Combination of grinding and clenching marks:**
  ☐ Right
  ☐ Front
  ☐ Left
- **Fractures or perforations:**
  ☐ Right
  ☐ Front
  ☐ Left

Assessment by Instrument-Based Analysis (IBA)
Technology Report

A7. Sleep Bruxism

A7.1 Electromyography (EMG):

- Number of masseter EMG activities exceeding 10% of maximum voluntary clenching: _____
- Bruxism time index (if available): _____
- Bruxism work index (if available): _____

A7.2 Polysomnography (Optional):

- Number of arousal-related SB (Sleep Bruxism) events: _____
- Number of arousal-unrelated SB (Sleep Bruxism) events: _____
- Bruxism time index (if available): _____
- Bruxism work index (if available): _____

A7.3 Other Methods (Optional):

- Scores for grinding sounds recorded by smartphone applications.

A7.4 Sensor-Integrated Devices (Optional):

- Number of chewing pressure/force activities: _____

A8. Awake Bruxism

A8.1 Ecological Momentary Assessment - One Week Report

Condition	Week 1 (%)	Additional Week(s) (%)
Relaxed jaw muscles (no teeth contact)		
Holding the mandible tense (no teeth contact)		
Teeth Contact (light and steady touch)		
Teeth Clenching (strong and steady contact)		
Teeth Grinding		

A8.2 Awake Electromyography (EMG):

- Number of masseter EMG activities exceeding 10% of maximum voluntary clenching: _____
- Bruxism time index: _____
- Bruxism work index: _____

A8.3 Other Methods:

- Not yet determined.

A9. Additional Tools

A9.1 Intraoral Acidity (Optional):

- Resting salivary pH: _____
- Resting salivary flow: _____
- Stimulated salivary pH (with paraffin): _____
- Stimulated salivary flow: _____

B1. Psychosocial Assessment
Self-Report

B1.1 Anxiety and Depression Screening
Over the past two weeks, how often have you been bothered by 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. **Taking less pleasure in things or losing interest in activities**
   ☐ 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
Indicate how well 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
   ☐ Neutral
   ☐ 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
   ☐ Neutral
   ☐ 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
   ☐ Neutral
   ☐ 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
   ☐ Neutral
   ☐ Describes me
   ☐ Describes me very well

B2. Assessment of Coexisting Sleep-Related Conditions
Self-Report

B2.1 Sleep Apnea Screening
Please mark which of the following questions you answered positively:

☐ Do you snore loudly?
☐ Do you often feel tired, fatigued, or sleepy during the day?
☐ Has anyone observed you stop breathing or choking/gasping during sleep?
☐ Do you have or are you being treated for high blood pressure?
☐ Is your Body Mass Index (BMI) over 35?
☐ Are you older than 50?
☐ Is your neck circumference large? (43 cm or larger for males; 41 cm or larger for females)
☐ Is your gender male?

B2.2 Insomnia Screening
Please indicate which of the following statements apply to you:

☐ I have difficulty falling asleep.
☐ Thoughts race through my mind and prevent me from sleeping.
☐ I anticipate having sleep problems several 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.
☐ I lie awake in bed for half an hour or more before falling asleep.

B2.3 Periodic Limb Movement Disorder and Restless Legs Syndrome Screening
Please indicate which of the following statements apply to you:

☐ I feel muscle tension in my legs, even when not exercising.
☐ I have noticed (or others have commented) that parts of my body jerk during sleep.
☐ I have been told that I kick at night.
☐ When trying to sleep, I experience an aching or crawling sensation in my legs.
☐ I feel leg pain and cramps at night.
☐ Sometimes, I cannot keep my legs still at night. I must move them to feel comfortable.
☐ Even though I sleep during the night, I feel sleepy during the day.

B2.4 Oral Behaviors - Sleep Position

Based on the past month, how often do you sleep in a position that puts pressure on your jaw?
☐ Never
☐ Rarely
☐ Sometimes
☐ Often
☐ Always
☐ Don't know

B3. Assessment of Non-Sleep-Related Accompanying Conditions
B3.1 Oral Behaviors - Activities Performed During Waking Hours
Based on the past month, indicate how often you have engaged in the following activities:

Question 7. Holding or pushing the jaw forward or to the side:
☐ Never
☐ Rarely
☐ Sometimes
☐ Often
☐ Always
☐ Don't know

Question 8. Pressing the tongue forcefully against the teeth:
☐ Never
☐ Rarely
☐ Sometimes
☐ Often
☐ Always
☐ Don't know

Question 9. Placing the tongue between the teeth:
☐ Never
☐ Rarely
☐ Sometimes
☐ Often
☐ Always
☐ Don't know

Question 10. Biting, chewing, or playing with the tongue, cheeks, or lips:
☐ Never
☐ Rarely
☐ Sometimes
☐ Often
☐ Always
☐ Don't know

Question 11. Holding the jaw in a tight or rigid position to support or protect it:
☐ Never
☐ Rarely
☐ Sometimes
☐ Often
☐ Always
☐ Don't know

Based on the past month, indicate how often you have engaged in the following activities:

Question 12. Holding or biting objects such as hair, pipes, pencils, fingers, or nails between the teeth:
☐ Never
☐ Rarely
☐ Sometimes
☐ Often
☐ Always
☐ Don't know

Question 13. Chewing gum:
☐ Never
☐ Rarely
☐ Sometimes
☐ Often
☐ Always
☐ Don't know

Question 14. Playing a musical instrument that involves the use of the mouth or jaw:
☐ Never
☐ Rarely
☐ Sometimes
☐ Often
☐ Always
☐ Don't know

Question 15. Resting your hand on your jaw or using your hand to support your chin:
☐ Never
☐ Rarely
☐ Sometimes
☐ Often
☐ Always
☐ Don't know

Question 16. Chewing food only on one side:
☐ Never
☐ Rarely
☐ Sometimes
☐ Often
☐ Always
☐ Don't know

Question 17. Eating between meals:
☐ Never
☐ Rarely
☐ Sometimes
☐ Often
☐ Always
☐ Don't know

Question 18. Sustained talking (e.g., teaching, sales, customer services):
☐ Never
☐ Rarely
☐ Sometimes
☐ Often
☐ Always
☐ Don't know

Question 19. Singing:
☐ Never

☐ Rarely
☐ Sometimes
☐ Often
☐ Always
☐ Don’t know

Question 20. Yawning:
☐ Never
☐ Rarely
☐ Sometimes
☐ Often
☐ Always
☐ Don’t know

Question 21. Holding the phone between your head and shoulder:
☐ Never
☐ Rarely
☐ Sometimes
☐ Often
☐ Always
☐ Don’t know

B3.2 Smartphone Usage (Optional Item)
Indicate your average daily smartphone usage time:

B3.3 Orofacial Motor Disorders
Do you experience symptoms of or have you been diagnosed with any of the following conditions?
☐ Orofacial Dyskinesia
☐ Oromandibular Dystonia
☐ Parkinson's Disease
☐ Huntington's Disease
☐ Tourette Syndrome
☐ Hemifacial Spasm
☐ Tardive Dyskinesia

B3.4 Gastroesophageal Reflux Disease (GERD) Screening
How many days per week do you experience the following symptoms?

A. Burning sensation behind the breastbone (heartburn):
☐ 0 Days
☐ 1 Day

☐ 2-3 Days
☐ 4-7 Days

B. Stomach contents moving up into the throat or mouth (regurgitation):
☐ 0 Days
☐ 1 Day
☐ 2-3 Days
☐ 4-7 Days

C. Pain in the middle or upper stomach area:
☐ 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 night's sleep due to heartburn or regurgitation:
☐ 0 Days
☐ 1 Day
☐ 2-3 Days
☐ 4-7 Days

F. Need to use over-the-counter medication for heartburn or regurgitation:
☐ 0 Days
☐ 1 Day
☐ 2-3 Days
☐ 4-7 Days

B3.5 Screening for Autoimmune or Connective Tissue Disorders
Have you been diagnosed with any of the following conditions?
☐ Rheumatoid Arthritis
☐ Lupus
☐ Other systemic rheumatic diseases (including fibromyalgia)
☐ Other systemic conditions (including systemic sclerosis, polymyalgia rheumatica, mixed connective tissue disease)

B3.6 Attention Deficit Hyperactivity Disorder (ADHD)
Have you been diagnosed with Attention Deficit Hyperactivity Disorder (ADHD)?
☐ No
☐ Yes

B4. Assessment of Prescribed Medications and Substance Use Self-Assessment

B4.1 Drugs
Do you use recreational or street drugs?
☐ Yes
☐ No

If yes, please specify which drugs you use:

B4.2 Medications
Are you currently taking any of the following medications?
☐ Antidepressants (e.g., Selective Serotonin Reuptake Inhibitors - SSRI)
☐ Benzodiazepines
☐ Neuroleptics, Antipsychotics, Antiemetics (Dopamine antagonists)
☐ ADHD medications
☐ Anti-allergic medication
☐ Medical cannabis CBD
☐ Medical cannabis THC
☐ Opioids
☐ Others

If yes, please list all the medications you are taking, along with their dosages:

B4.3 Tobacco
Do you smoke or use any tobacco products?
☐ No
☐ Yes
☐ Quit

If yes, how many cigarettes do you smoke per day?
Number: _____

B4.4 Alcohol
Do you consume alcoholic beverages (beer, wine, hard liquor)?

☐ No
☐ Yes
☐ Quit

If yes, please indicate your approximate consumption (glasses/day): _____

B4.5 Carbonated Beverages
Do you regularly drink carbonated beverages (e.g., Cola, RedBull, Sprite, Fanta)?
☐ No
☐ Yes
☐ Quit

If yes, please indicate your approximate consumption (glasses/day): _____

B4.6 Fruits and Fruit Juices
Do you regularly consume fruit juices or acidic fruits (e.g., lemon, orange, grapefruit)?
☐ No
☐ Yes
☐ Quit

If yes, please indicate your approximate consumption (glasses/day): _____

B4.7 Caffeine Consumption
Do you regularly consume coffee, tea, or other caffeine-containing beverages?
☐ No
☐ Yes
☐ Quit

If yes, please indicate your approximate consumption (cups/day): _____

B5. Assessment of Additional Factors

B5.1 Familial Bruxism Screening
Do you know anyone in your family (e.g., father, mother, children) with a history of bruxism?
☐ No
☐ Yes (Father/Mother/Son/Daughter/Grandfather/Grandmother)
☐ Don't know

B5.2 Familial Tooth Wear Screening
Do you know anyone in your family (e.g., father, mother, children) with tooth wear?
☐ No
☐ Yes (Father/Mother/Son/Daughter/Grandfather/Grandmother)
☐ Don't know

B5.3 Familial Sleep Apnea Screening
Do you know anyone in your family (e.g., father, mother, children) with sleep apnea?
☐ No
☐ Yes (Father/Mother/Son/Daughter/Grandfather/Grandmother)
☐ Don't know

B5.4 Familial Orofacial Pain Screening
Do you know anyone in your family (e.g., father, mother, children) experiencing non-dental facial pain?
☐ No
☐ Yes (Father/Mother/Son/Daughter/Grandfather/Grandmother)
☐ Don't know

B5.5 Familial Gastroesophageal Reflux Disease (GERD) Screening
Do you know anyone in your family (e.g., father, mother, children) with gastroesophageal reflux disease (GERD)?
☐ No
☐ Yes (Father/Mother/Son/Daughter/Grandfather/Grandmother)
☐ Don't know