BACK TRANSLATION 2

Standardized Tool for the Assessment of Bruxism

STAB

Complete Tool

ITALIAN VERSION

January 2023

Index

Standardized Tool for the Assessment of Bruxism (STAB)

Demographic Questionnaire

Gender
Male
Female
Not specified/Others

Age **Height** **Weight**
_____ **_____** **_____**

What is your marital status?
Married
Cohabitation
Divorced
Separated
Widowed
Unmarried

What is your ethnicity? Mark all the options needed
Asian
Afro-American
Caucasian
Others (Specify)

What is the highest degree or level of education you have completed?
Compulsory school (<16 years)
Secondary school (eg., high school) up to 18 years
University (without degree)
Graduated
Post-graduated 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 while asleep in the last month? (based on any information you may 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 SLEEP BRUXISM HISTORY QUESTION
Did you use to clench or grind your teeth while asleep in the past? (based on any information you may have)
No
Yes
Don't know

A2. Awake Bruxism Report

A2.1 AWAKE TEETH GRINDING QUESTION
How often do you grind your teeth during the waking hours in the last month?

Never
Almost never
Sometimes
Most of the time
Always
Don't know

A2.1.1 AWAKE TEETH GRINDING HISTORY QUESTION
Did you use to grind your teeth during the waking hours in the past?

No
Yes
Don't know

A2.2 AWAKE TEETH CLENCHING QUESTION
How often do you clench your teeth during the waking hours in the last month?

Never
Almost never
Sometimes
Most of the time
Always
Don't know

A2.2.1 AWAKE TEETH CLENCHING HISTORY QUESTION
Did you use to clench your teeth during the waking hours in the past?

No
Yes
Don't know

A2.3 AWAKE TEETH CONTACT QUESTION
How often do you press, touch or hold your teeth on contact together other than while eating in the last month (contact between upper and lower teeth)?

Never
Almost never
Sometimes
Most of the time
Always
Don't know

A2.3.1 AWAKE TEETH CONTACT HISTORY QUESTION
Did you use to press, touch or hold your teeth on contact together other than while eating in the past (contact between upper and lower teeth)?

No
Yes
Don't know

A2.4 AWAKE BRACING QUESTION
How often do you tense your muscles without clenching or holding your teeth on contact in the last month?

Never
Almost never
Sometimes
Most of the time
Always
Don't know

A2.4.1 AWAKE BRACING HISTORY QUESTION
Did you use to tense your muscles without clenching or holding your teeth on contact in the past?

No
Yes
Don't know

A3. Patient's complaints

TEMPOROMANDIBULAR DISORDERS

A3.1 PAIN IN TEMPOROMANDIBULAR DISORDERS
In the last 30 days, how long have you felt pain in the jaw or temple area on either side?

No pain
Pain comes and goes
Constant pain

A3.2 PAIN OR STIFFNESS ON AWAKENING
In the last 30 days, have you had pain or stiffness in your jaw on awakening?

No
Yes

A3.3 JAW CLOSED LOCK
In the last 30 days, have you had your jaw locked, event for a moment, that you could not open your mouth?

No
Yes

A3.4 PAIN CHANGES WITH ACTIVITIES
In the last 30 days, did the following activities change any pain (for better or worse) in your jaw or temple on either side?

Chewing hard or tough food
Opening the mouth or moving the jaw forward or on the side
Holding teeth on contact together, clenching, grinding or chewing gum
Other activities (eg., talking, kissing, yawning)

A3.5 NOISES IN JAW JOINT
In the last 30 days, have you heard any noises in your jaw joint when you moved your jaw?

No
Yes

A3.6 MUSCLE PAIN IN THE WAKING HOURS

In the last 30 days, have you had jaw muscle pain in at least one of the following times of the day?

Between awakening and breakfast
Between breakfast and lunch
Between lunch and dinner
Between dinner and bedtime

A3.6.1 TIREDNESS OR MUSCLE FATIGUE IN THE WAKING HOURS

In the last 30 days, have you had any jaw muscle tiredness, fatigue or stiffness in at least one of the following times of the day?

Between awakening and breakfast
Between breakfast and lunch
Between lunch and dinner
Between dinner and bedtime

A3.7 AWAKENING SYMPTOMS QUESTION

Are you aware of one of the following symptoms upon awakening?

Sensation of fatigue, soreness or tightness of your jaw
Feeling that your teeth are clenched or that your mouth is sore
Aching of your temples
Feeling of tension in your jaw joint upon awakening and feeling that you have to move your jaw to release it
Difficulty in opening mouth wide upon awakening
Hearing or feeling a click in your jaw joint upon awakening that disappears afterwards

HEADACHE

A3.8 HEADACHE

In the last 30 days, have you had any headache that included the temple area?

No
Yes
If yes, how many days?

TOOTH WEAR

A3.9 USURA DENTALE

Have you ever experienced any of the following symptoms because of the tooth wear?

Sensitivity and/or pain: yes/no
Functional problems (difficulties chewing and eating): yes/no
Deterioration of esthetic appearance (compromised aesthetics of the smile): yes/no
Crumbling of dental hard tissue and restorations: yes/no
Phonetic impairment: yes/no

TINNITUS

A3.10 TINNITUS
Do you have noises or ringing in your ears (tinnitus)?
No
Yes

XEROSTOMIA E DROOLING

A3.11 XEROSTOMIA
Do you feel your mouth dry?
Never
Occasionally
Often

A3.12 DROOLING
Have you ever had loss of saliva during the night?

I have never had loss of saliva during the night at all
My pillow sometimes gets wet during the night
My pillow regularly gets wet during the night
My pillow always gets wet during the night
Every night my pillow and other sheets get wet

Clinical-based assessment (CBA) – Examiner's report (FOR EXAMINER'S USE)

A4. Joints and MusclesArticolazioni e Muscoli

A4.1 DIAGNOSIS OF TEMPOROMANDIBULAR DISORDERS
Mark the presence of the following diagnosis

A4.1.1. PAIN DISORDERS*
* Please fill this section only if the item A3.3 (TMD Pain Screener) is positively endorsed by the patient
Myalgia
Myofascial pain with spreading
Myofascial pain with referral
Right arthralgia
Left arthralgia
Headache attributed to TMD

A4.1.2. RIGHT TMJ DISORDERS *
* Please specify if diagnosis is based upon clinical or imaging assessment
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 DISORDERS*
* Please specify if diagnosis is based upon clinical or imaging assessment
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
Mark the presence of masseter hypertrophy:
Left
Right

A5. Intraoral and extraoral Tissues

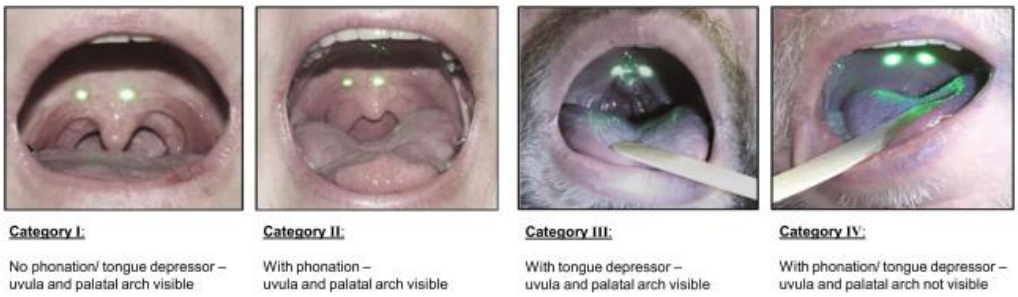
A5.1 SOFT AND HARD TISSUES

Mark the presence of the following signs:

White Line	Left	Right	
Lip Dental Impressions	Upper	Lower	
Cheek dental impressions	Left	Front	Right
Tongue ulcerations*	Left	Front	Right
Alveolar Bone Exostosis	Mandible (Buccal/Lingual)		
Maxilla(Buccal/palatal/Mid-palatal)			

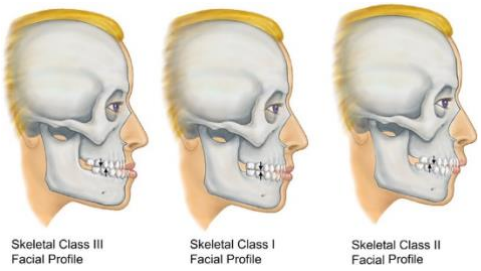
* If positive for firm, hard, rolled borders – red flag for further urgent investigation

A5.2 MODIFIED FREIDMAN TONGUE POSITION



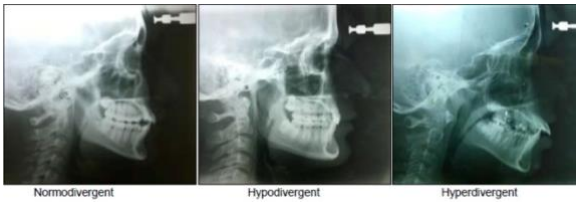
A5.3 SKELETAL CLASS (Optional)

Class 1
Class 2
Class 3



A5.4 SKELETAL PROFILE (Optional)

Normodivergent profile (Medium gonial angle)
Hypodivergent profile (Low gonial angle)
Hyperdivergent profile (High gonial angle)



A6. Teeth and Restorations

A6.1 TOOTH WEAR SCREENING – QUANTIFICATION

Indicate the highest tooth wear score per sextant

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

A.6.1.1 TOOTH WEAR QUALIFICATION*

* When during quantification a grade ≥ 2 is detected, qualification is needed.

Clinical signs indicating the influence of mechanical factors:

Shiny, flat and glossy facets
Enamel and dentin wear at the same rate
Matching wear on occlusal surfaces corresponding to the antagonistic teeth
Fracture of cusps or restorations
Impressions in cheek, tongue and/or lip
Non Carious Cervical Lesions (NCCL) in cervical areas of the teeth
Non Carious Cervical Lesions (NCCL) in Buccal/cervical area more wide than deep
Cervical areas of premolars and cuspids affected
Cracks within the enamel
Torus mandibulae

A6.2 PARODONTAL AND DENTAL EXAMINATION

Indicate the number of teeth with the following signs

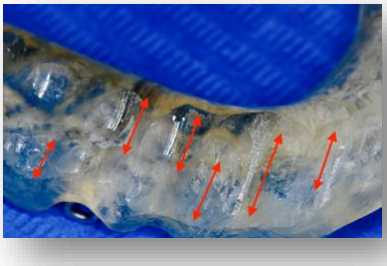
	Sextant 1	Sextant 2	Sextant 3	Sextant 4	Sextant 5	Sextant 6
Mobility						
Thermal sensitivity						
Discomfort/pain on biting						
Fractured teeth						

A6.3 RESTORATIONS
Indicate the number of teeth/implants 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						

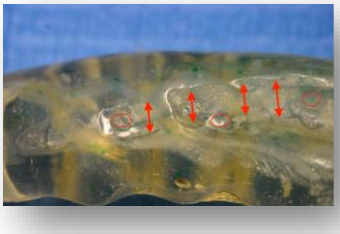
A6.4 ORAL APPLIANCE EVALUATION (hard resin intraoral plate used by the patient)
Indicate the presence of the following signs:

Prevalence of grinding marks (i.e., stripes)	Left	Front	Right
Prevalence of clenching marks (i.e., circle-like spots)	Left	Front	Right
Combination of grinding and clenching marks	Left	Front	Right
Fractures or perforations	Left	Front	Right



Example of grinding marks

Example of clenching marks.



Example of combined marks.

Instrumental-based assessment (IBA) – Instrumental 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)

Smartphone application scores for grinding

A7.4 APPLIANCE WITH SENSORS (Optional)

Number of events of bite pressure

A8. Awake Bruxism

A8.1 ECOLOGICAL MOMENTARY ASSESSMENT - One week report

CONDITION	Week 1 (in %)	Additional week (in %)
Relaxed jaw muscles (no teeth contact)		
Mandible bracing (no teeth contact)		
Teeth Contact (light steady touching)		
Teeth Clenching (strong steady touching)		
Teeth Grinding		

A8.2 ELECTROMYOGRAPHY IN THE WAKING HOURS

Number of masseter events over 10% MVC _____
Bruxism time index (if available) _____
Bruxism work index (if available) _____

A8.3 OTHERS METHODS: to be determinated

A9. Additional Tools

A9.1. Intraoral acidity (Optional)

REST SALIVARY PH _____
REST SALIVARY FLOW _____
STIMULATED SALIVARY PH (paraffin) _____
STIMULATED SALIVARY FLOW _____

Axis B – Risk and etiological factors and comorbidities

B1. Psychosocial Assessment– Self Report

B1.1 Anxiety and depression screening

In the last two weeks, how often did you feel disturbed by the following problems?

1. Feeling nervous, anxious or on edge
Never
Several days
More than half the days
Nearly every day

2. Not being able to stop or control concerns
Never
Several days
More than half the days
Nearly every day

3. Little interest or pleasure in doing things
Never
Several days
More than half the days
Nearly every day

4. Feeling down, depressed or hopeless
Never
Several days
More than half the days
Nearly every day

B1.2 COPING

Consider how well the following statements describe your behaviors and actions

1. I tend to look for creative ways to change 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
No matter what happens to me, I'm confident 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
I believe I can learn positive things 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
I actively look for ways to replace the losses that happen in my in life
Does not describe me
Neutral
Describes me
Describes me very well

* https://www.frontiersin.org/articles/10.3389/fpsyg.2021.641213/full

B2. Assessment of concurrent sleep-related conditions– Self Report

B2.1 SLEEP APNEA SCREENING
Please mark which of the following questions is answered positively
Do you often feel tired, fatigued or sleepy in the daytime?
Has anyone observed you stop breathing during sleep?
Do you have or have you been treated for high blood pressure?
Is your Body Mass Index (BMI) more than 35 kg/m^2?
Is your age more than 50 years?
Is your neck size: for male 43 cm or larger?
For female 41 cm or larger?
Is your gender male?

B2.2 INSOMNIA SCREENING
Indicate which of the following statements can be applied to you

I have difficulty falling asleep
Thoughts race through my mind and prevent me from sleeping
I anticipate a problem with sleep several times a week
I wake up and cannot go back to sleep
I worry about things and have problems relaxing
I wake up earlier in the morning than I would like to
I lie awake for half an hour or more before I fall asleep

B2.3 PERIODIC LIMB MOVEMENT DISORDER and RESTLESS LEG SYNDROME SCREENING
Indicate which of the following statements can be applied to you
Other than when exercising, I still experience muscle tension in my legs
I have noticed (or other have commented) that parts of my body jerk during sleep
I have been told that I kick at night
When trying to go sleep, I experience an aching or tingling ???? sensation in my legs
I experience leg pain and cramps at night
Sometimes I can't keep my legs still at night. I just have to move them to feel comfortable
Even though I slept during the night, I feel sleepy during the day

B2. ORAL BEHAVIORS - SLEEP POSITION
How often do you sleep in a position that puts pressure on the jaw, based on the last month?

Never
Almost never
Sometimes
Most of the time
Always
Don't know

B3. Assessment of concurrent non-sleep 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. Hold or push jaw forward or to the side

Never
Almost never
Sometimes
Most of the time
Always
Don't know

Q8. Press tongue strongly against teeth

Never
Almost never
Sometimes
Most of the time
Always
Don't know

Q9. Place tongue between teeth

Never
Almost never
Sometimes
Most of the time
Always
Don't know

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

Never
Almost never
Sometimes
Most of the time
Always
Don't know

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

Never
Almost never
Sometimes
Most of the time

Always
Don’t know

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

Never
Almost never
Sometimes
Most of the time
Always
Don’t know

Q13. Use chewing gum

Never
Almost never
Sometimes
Most of the time
Always
Don’t know

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

Never
Almost never
Sometimes
Most of the time
Always
Don’t know

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

Never
Almost never
Sometimes
Most of the time
Always
Don’t know

Q16. Chew food on one side only

Never
Almost never
Sometimes
Most of the time
Always
Don’t know

Q17. Eating between meals

Never
Almost never
Sometimes
Most of the time
Always
Don’t know

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

Never
Almost never
Sometimes
Most of the time
Always
Don’t know

Q19. Singing

Never
Almost never
Sometimes
Most of the time
Always
Don’t know

Q20. Yawning

Never
Almost never
Sometimes
Most of the time
Always
Don’t know

Q21. Hold telephone between your head and shoulders

Never
Almost never
Sometimes
Most of the time
Always
Don’t know

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

B3.3 OROFACIAL MOTOR DISORDERS
Have you been diagnosed with or do you suffer from possible signs of one of the following conditions?

Orofacial Dyskinesia
Oromandibular Dystonia
Parkinson's Disease
Huntington's Disease
Tourette's Syndrome
Hemifacial Spasms
Tardive Dyskinesia

B3.4 GASTROAESOPHAGEAL REFLUX DISEASE SCREENING
How many times per week do each of the following symptoms occur?

A. Burning feeling behind the breastbone (heartburn)

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

B. Stomach contents moving up to 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. Trouble getting a good night's sleep because of heartburn or regurgitation

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

F. Need for over-the-counter medicine for heartburn or regurgitation

0 Days

1 Day
2-3 Days
4-7 Days

B3.5 AUTOIMMUNE OR CONNECTIVE TISSUE DISORDERS SCREENING
Have you been diagnosed with one of the following conditions?

Rheumatoid Arthritis
Lupus
Other systemic rheumatic diseases, including fibromyalgia
Other systemic conditions, including systemic sclerosis, rheumatic polymyalgia, mixed connective disease

B3.6 ATTENTION DEFICIT HYPERACTIVITY DISORDER
Have you been diagnosed with Attention Deficit Hyperactive Disorder?
No
Yes

B4. Assessment of prescribed medicines and use of drugs – 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-allergic medication
Medical marijuana CBD
Medical marijuana TSH
Opioids
Others

If yes, please list all the medications and dosage

_____

B4.3 TOBACCO

Do you smoke or use any tobacco products?

No
Yes
Quit

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

B4.4 ALCOHOL

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

No
Yes
Quit

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

B4.5 SOFT DRINKS

Do you regularly drink sparkling drinks (e.g., Cola – RedBull – Sprite – Fanta)?

No
Yes
Quit

If yes, what is your approximate intake (glasses/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. Additional assessments

B5.1 FAMILIAR BRUXISM SCREENING
Do you know of anyone in your family (for example, father, mother, children) who has had any history of bruxism occurrence?
No
Yes Father/Mother/Son/Daughter/Grandfather/Grandmother
Don't know

B5.2 FAMILIAR TOOTH WEAR SCREENING
Do you know of anyone in your family (for example, father, mother, children) who has tooth wear?

No
Yes Father/Mother/Son/Daughter/Grandfather/Grandmother
Don't know

B5.3 FAMILIAR OSA SCREENING
Do you know of anyone in your family (for example, father, mother, children) who has sleep apnea?

No
Yes Father/Mother/Son/Daughter/Grandfather/Grandmother
Don't know

B5.4 FAMILIAR OROFACIAL PAIN SCREENING
Do you know of anyone in your family (for example, father, mother, children) who has non-dental facial pain?

No
Yes Father/Mother/Son/Daughter/Grandfather/Grandmother
Don't know

B5.5 FAMILIAR GERD SCREENING
Do you know of anyone in your family (for example, father, mother, children) who has gastroaesophageal reflux disease?

No
Yes Father/Mother/Son/Daughter/Grandfather/Grandmother
Don't know