



Original language: English

Translation to: _____

Date of translation: _____

Translation team

Project leader: _____

Team leader: _____

Study coordinator 1: _____

Study coordinator 2: _____

Study coordinator 3: _____

Forward translator 1: _____

Forward translator 2: _____

Back- translator 1: _____

Back- translator 2: _____

Collaborators

Expert panellist 1: _____

Expert panellist 2: _____

Expert panellist 3: _____

Expert panellist 4: _____

Expert panellist 5: _____



Standardized Tool for the Assessment of Bruxism (STAB)

Demographics 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)

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

Some University (no degree) _____
University graduate _____
Post-graduate level _____

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 one 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 TEETH GRINDING QUESTION

How often do you grind 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 _____

A2.1.1 AWAKE TEETH GRINDING HISTORY QUESTION

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

No _____

Yes _____

Don't know _____

A2.2 AWAKE TEETH CLENCHING QUESTION

How often do 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 do you press, touch, or hold your teeth together other than while eating (that is, contact between upper and lower teeth), 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 _____

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A2.3.1 AWAKE TEETH CONTACT HISTORY QUESTION

Did you use to press, touch, or hold your teeth together other than while eating (that is, contact between upper and lower teeth) in the past?

No _____

Yes _____

Don't know _____

A2.4 AWAKE MANDIBLE BRACING QUESTION

How often do you hold, tighten, or tense your muscles without clenching or bringing 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 MANDIBLE BRACING 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

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

No pain _____

Pain comes and goes _____

Pain is always present _____

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 CLOSED LOCK

In the last 30 days, have you had your jaw locked or caught, even for a moment, so it would not open ALL THE WAY?

No _____

Yes _____

A3.4 PAIN CHANGE WITH ACTIVITIES

In the last 30 days, did the following activities change any pain (that is, make it better or make it worse) in your jaw or temple on either side?

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 had any jaw joint noise(s) when you moved or used your jaw?

No _____
Yes _____

A3.6 WAKETIME MUSCLE PAIN

In the last 30 days, did you have jaw muscle pain 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 last 30 days, did you have jaw muscle stiffness or sensation or tiredness or fatigue 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

A3.7 AWAKENING SYMPTOMS QUESTION

Are you aware of any 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 lower 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

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? _____

A3.9 TOOTH WEAR

Do you experience any of the following symptoms because of the existing tooth wear?

Sensitivity and/or pain _____

Functional problems (difficulties chewing and eating)

Deterioration of esthetic appearance (compromised dental attractiveness) Crumbling of dental hard tissue and restorations

Phonetic impairment _____

A3.10 TINNITUS

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

No _____

Yes _____

A3.11 XEROSTOMIA

Does your mouth feel dry? _____

Never _____

Occasionally _____

Often _____

A3.12 DROOLING

Do you experience loss of saliva during the night?

I do not experience 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 bedclothes get wet

Clinically Based Assessment (CBA)

Examiner Report (FOR EXAMINER'S USE)

A4. Joints and muscles

A4.1 TMD DIAGNOSES (Optional Item)

Mark the presence of the following diagnoses

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 MUSCLE HYPERTROPHY _____

Mark the presence of masseter hypertrophy:

Left _____

Right _____

A5. Intra- and Extra-oral tissues

A5.1 SOFT AND BONE TISSUES

Mark 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/Midpalatal) _____

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

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 _____

Facial Profile _____



Skeletal Class III
Facial Profile



Skeletal Class I
Facial Profile



Skeletal Class II
Facial Profile

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 – 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 facets, flat and glossy

Enamel and dentin wear at the same rate

Matching wear on occluding surfaces, corresponding features at the antagonistic teeth

Fracture of cusps or restorations

Impressions in cheek, tongue and/or lip

Located at cervical areas of the teeth, Non Carious Cervical Lesions (NCCL)

Buccal/cervical lesions more wide than deep, Non Carious Cervical Lesions (NCCL)

Cervical areas of premolars and cuspids are affected

Cracks within the enamel

Torus mandibulae

A6.2 PERIODONTAL 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 (If hard resin splint is used by the patient)

Mark the presence of the following signs:

Prevalence of grinding marks (i.e., stripes)

Right _____

Front _____

Left _____

Prevalence of clenching marks (i.e., circle-like spots)

Right _____

Front _____

Left _____

Combination of grinding and clenching marks

Right _____

Front _____

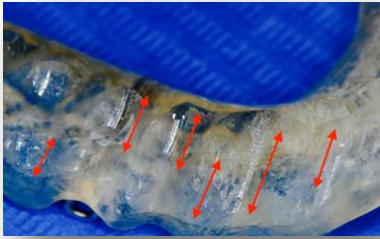
Left _____

Fractures or perforations

Right _____

Front _____

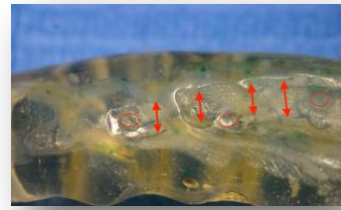
Left _____



Example of grinding marks



Example of clenching marks.



Example of combined marks.

Instrumentally 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)

Smartphone application scores for grinding sounds

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(s) (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 WAKE-TIME ELECTROMYOGRAPHY

Number of masseter events over 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 and Etiological 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 _____

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 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 at all _____
Does not describe me _____
Neutral _____
Describes me _____
Describes me very well _____

B2. Concurrent sleep-related conditions assessment

Self Report

B2.1 SLEEP APNEA SCREENING

Please mark which of the following questions is answered positively

Do you snore loudly?

Do you often feel tired, fatigued or sleepy during daytime?

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

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

Body mass Index more than 35?

Age older than 50?

Neck size large (43 cm or larger for males; 41 cm or larger for females)?

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 crawling 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

B2.4 ORAL BEHAVIORS - SLEEP POSITION

How often do you sleep in a position that puts pressure on the jaw, 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 _____

B3. Concurrent non-sleep conditions assessment

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 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 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 GASTROESOPHAGEAL 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 _____

A. Stomach contents moving up to the throat or mouth (regurgitation)

0 Days _____

1 Day _____

2-3 Days _____

4-7 Days _____

B. Pain in the middle or upper stomach area

0 Days _____

1 Day _____

2-3 Days _____

4-7 Days _____

C. Nausea _____

0 Days _____

1 Day _____

2-3 Days _____

4-7 Days _____

D. Trouble getting a good night's sleep because of heartburn or regurgitation

0 Days _____

1 Day _____

2-3 Days _____

4-7 Days _____

E. 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. Prescribed medications and use of substances assessment

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 (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 factors assessment

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 gastroesophageal reflux disease?

No _____

Yes _____

Father/Mother/Son/Daughter/Grandfather/Grandmother

Don't know _____