COMUM BACK TRANSLATION

Standartized Tool for the Assessment of Bruxism
Demografic Quesitionnaire

Sex

Male

Female

Unespecified/ Other

Age

Height

Weight

What is your current marital status?
Married

Divorced

Separated

Widowed

Never were married

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

Middle-school (<16YEARS)

High school
Some time in university (without graduating)

Post-graduate level

Subject Based Assessment (SBA) Self Report

A1. Sleep Report

A1.1 Sleep Bruxism Questions

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

(All standardized answers are as below)

Never

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?

(All standardized answers are as below)

No

Yes

I 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?

(All standardized answers are as below)

Not even once

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?

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

A2.2.1 AWAKE TEETH CLENCHING HISTORY QUESTION

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

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?

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?

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?

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?

A3. Patients'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?

A3.2 PAIN OR STIFFNESS ON AWAKENING

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

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?

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?

A3.6 AWAKETIME 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 AWAKETIME 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?

(All standardized answers are as below)

No

Yes

If yes – for 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 Impaiment

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*

A4.1.3. LEFT TMJ DISORDERS*

(All standardized answers are as below)

*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:

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

A5.3 SKELETAL CLASS (Optional Item)

Class 1

Class 2

Class 3

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. Teeth and restorations

Indicate the highest tooth wear score per sextant

Sextant 1

Sextant 2

Sextant 3

Sextant 4

Sextant 5

Sextant 6

Oclusal/ 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

(All standardized answers are as below)

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

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:]

(All standardized answers are as below)

Right Front Left

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

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

Combination of grinding and clenching marks

Fractures or perforations

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

Relaxed jaw muscles (no teeth contact)

Mandible bracing (no teeth contact)

Teeth Contact (light steady touching)

Teeth Clenching (strong steady touching)

Teeth Grinding

Week 1 (in %)

Additional week(s) (in %)

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 SALVIARY 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?

Not at all

Several days

More than half the days

Nearly every day

(All standardized answers are as below)

1. Feeling nervous, anxious or on edge

2. Not being able to stop or control worrying

3. Little interest or pleasure in doing things

4. Feeling down, depressed, or hopeless

B1.2 COPING

Consider how well the following statements describe your behaviors and actions

(All standardized answers are as below)

Does not describe me at all

Does not describe me

Neutral

Describes me

Describes me very well

1. I look for creative ways to alter difficult situations

2. Regardless of what happens to me, I believe I can control my reaction to it

3. I Believe I can grow in positive ways by dealing with difficult situations
4. I actively look for ways to replace the losses I encounter in life Does not describe me at all

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

(All standardized answers are as below)

None of the time

A little of the time

Some of the time

Most of the time

All of the time

Don’t know

Q7. Hold or jut jaw forward or to the side

Q8. Press tongue forcibly against teeth

Q9. Place tongue between teeth

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

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

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

Q13. Use chewing gum

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

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

Q16. Chew food on one side only

Q17. Eating between meals

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

Q19. Singing

Q20. Yawning

Q21. Hold telephone between your head and shoulders

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 GASTROAESOPHAGEAL REFLUX DISEASE SCREENING

How many times per week do each of the following symptoms occur?

(All standardized answers are as below)

0 Days

1 Day

2-3 Days

4-7 Days

A. Burning feeling behind the breastbone (heartburn)

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

C. Pain in the middle or upper stomach area

D. Nausea

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

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

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

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?

(All standardized answers are as below)

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)?

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

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

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)?

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

B4.7 CAFFEINATE

Do you regularly drink coffee, tea, or other caffeine beverages?

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?

(All standardized answers are as below)

No

Yes

Father/Mother/Son/Daughter/Grandfather/Grandmother

Don’t know

B5.2 FAMILIAR TOOTH WEAR SCREENING

B5.3 FAMILIAR OSA SCREENING

Do you know of anyone in your family (for example, father, mother, children) who has sleep apnea?

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?

B5.5 FAMILIAR GERD SCREENING

Do you know of anyone in your family (for example, father, mother, children) who has

gastroaesophageal reflux disease?