Axis A – Assessment of the status and consequences of bruxism

Subject assessment (SBA) – self-report

A1. Sleep bruxism report

A1.1 Question about bruxism during sleep

How often do you clench or grind your teeth while sleeping, in the last month (based on the information you have)?

Never
Less than one night per month
1-3 nights per month
1-3 nights per week
4-7 nights per week
I don't know

A1.1.1 Question about the history of sleep bruxism

To your knowledge, have you ever clenched or grinded your teeth while sleeping?

No
Yes
I don't know

A2. Report on bruxism during waking hours

A2.1 Question about teeth grinding while awake

How often do you grind your teeth when you are awake in the last month?

Not once
Rarely
Sometimes
Most of the time
All the time
I don't know

A2.1.1 Question regarding the history of teeth grinding during waking hours

Have you ever grinded your teeth when you are awake?

No
Yes
I don't know

A2.2 Question about teeth clenching while awake

How often do you clench your teeth when you are awake in the last month?

Not once
Rarely
Sometimes
Most of the time
All the time
I don’t know

A2.1.1. Question regarding the history of teeth clenching during wakefulness

Have you ever clenched your teeth when awake?

No
Yes
I don’t know

A2.3 Question regarding tooth contacts during waking hours

How often do you press, touch, or hold your teeth together apart from eating in the last month (i.e., contact between the upper and lower teeth)?

Not once
Rarely
Sometimes
Most of the time
All the time
I don’t know

A2.3.1 Question regarding the history of dental contacts during waking hours

Have you pressed, touched or held your teeth together differently than while eating (i.e., contact between the upper and lower teeth)?

No
Yes
I don’t know

A2.4 Question regarding stiffening the jaw while awake

How often do you tense your muscles without clenching or holding your teeth together over the past month?

Not once
Rarely
Sometimes
Most of the time
All the time

I don’t know

A2.4.1 Question regarding history of stiffening the jaw during wakefulness

Have you tensed your muscles in the past? Have you held your muscles tense without clenching or connecting your teeth?

No
Yes
I don't know

A3. Patient 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

Headache

3.8. Headache

Have you had headaches affecting the area around your temples in the last 30 days?

No
Yes
If so – for how many days?

Tooth wear

A3.9 Tooth wear

Are you experiencing any of the following symptoms due to existing tooth wear?

Sensitivity and/or a pain
Functional problems (difficulty chewing and eating)
Deterioration of aesthetic appearance (reduced attractiveness of the teeth)
Crushing of hard tooth tissues and restorations
Phonetics disorders

Tinnitus

A3.10 Tinnitus

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

No

Yes

Xerostomia and salivation

A3.11 Xerostomia

Do you feel dry in your mouth?

Never
Occasionally
Often

A3.12 Drooling

Do you experience loss of saliva at night?

I don’t experience any loss of saliva at night
Sometimes my pillow gets wet
My pillow often gets wet at night
My pillow always gets wet at night
Every night my pillow and bed linen get wet

Assessment based on clinical trial – researchers report (for researcher use)

A.4 Joints and muscles

A4.1 TMD diagnoses (optional)

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
A.4.1.2 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 Hypertrophy of the masseter muscle

Mark the presence of the masseter muscle hypertrophy

Left
Right

A5 Intra- and extraoral tissues

A5.1 Soft tissues and bone tissues

Indicate the presence of the following symptoms

Linea alba	Left	Right	
Impression on the lips	Upper	Lower	
Impression on the tongue	Right	Front	Left
Tongue ulcers*	Right	Front	Left
Exostoses on the aveolar process	Mandible (Buccal/Lingual)	Jaw (Buccal/Lingual/Mid-palatal)	

* In case of hard, hardened and curled edges – red flag, indication for urgent examination

A5.2 Friedman's modified tongue position

Category I – no phonation/tongue depressor – uvula and palatal arches visible
Category II – phonation - uvula and palatal arches visible
Category III – tongue depressor - uvula and palatal arch visible
Category IV – with phonation/tongue depressor - uvula and palatal arches invisible

A5.3 Skeleton class (optional position)

Class 1
Class 2
Class 3

A5.4 Skeleton profile (optional position)

Normodivergent profile (medium gonial angle)
Hipodivergent profile (low gonial angle)
Hiperdivergent profile (high gonial angle)

A6. Teeth and restorations

A6.1 Tooth wear screening – quantitative assessment

Indicate the highest tooth wear score on the sextant

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

A.6.1.1 Tooth wear qualification*

*If a grade ≥ 2 is detected during the quantitative assessment, qualification is required.
Clinical symptoms indicating the influence of mechanical factors:
Dials worn out, flat and shiny
Abrasion of enamel and dentin to the same extent
Matched wear of the occlusal surfaces, compatible features of antagonistic teeth
Fracture of the cusps or restorations
Impressions on the cheek, tongue and/or lip
Non-carious cervical lesions (NCCL) located on the tooth preparation surfaces
Non-carious cervical lesions (NCCL), malar lesions/cervical wider than deeper
Cervical surfaces of premolar and canine teeth are damaged
Cracked enamel
Mandibular shafts

A6.2 Periodontal and dental examination

Indicate the number of teeth with the following symptoms:

	Sextant 1	Sextant 2	Sextant 3	Sextant 4	Sextant 5	Sextant 6
Mobility						
Temperature sensitivity						
Discomfort/pain when biting						
Broken tooth						

A6.3 Restorations

Indicate the number of teeth with the following symptoms:

	Sextant 1	Sextant 2	Sextant 3	Sextant 4	Sextant 5	Sextant 6
Lost/damaged fillings						
Outlined restorations						
Ceramic cracks						
Loose implants						
Broken implants						
Loosening of the implant screw						

A6.4 Assessment of occlusal splints (if patient uses a hard resin splint)
Indicate the presence of the following symptoms:

Presence of grinding marks (i.e., streaks, stripes)	Right	Front	Left
Presence of clenching marks (i.e., places in the shape of a circle)	Right	Front	Left
Combination of grinding and clenching marks	Right	Front	Left
Cracks or perforations	Right	Front	Left

Instrument-Based Assessment Technology and Assessment Report (IBA).

A7. Bruxism during sleep

A7.1 Electromyography

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

A7.2 Polisomnography (optional)

Number of SB events related to awakening	
Number of SB events unrelated to awakening	
Bruxism time index (if available)	
Bruxism work index (if available)	

A.7.3 Other methods (optional)

Smartphone application for assessing grinding sounds

A7.4 Device with sensors (optional)

Number of events on pressure occlusion

A8. Bruxism during waking

A8.1 Ecological momentary assessment – weekly report

Condition	Week 1 (in %)	Additional weeks (in %)
Relaxed chewing muscles (lack of tooth contacts)		
Jaw stiffening (lack of tooth contacts)		
Dental contact (gentle, constant touching)		

Teeth clenching (strong, constant touching)		
Teeth grinding		

A8.2 Electromyography while awake

Number of masseter events over 10% MVC	
Bruxism time index	
Bruxism work index	

A8.3 Other methods: to be determined

A9. Additional devices

A9.1. Intraoral acidity (optional)

Resting pH of saliva	
Resting saliva flow	
Stimulated salivary pH (paraffin)	
Stimulated saliva flow	

Axis B Risk factors and etiological factors, and comorbidities

B1. Psychosocial assessment — self report

B1.1 Screening for anxiety and depression

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
Neutral
Describes me
Describes me very well

B2. Assessment of co-occurance of sleep related diseases – own report

B2.1 Sleep apnea screening

Select which of the following questions you will answer YES to

Do you snore loudly?
Do you often feel tired, exhausted or sleepy during the daytime?
Has anyone observed you stop breathing or choking/gasping during sleep?
Do you have a high blood pressure or are you being treated for high blood pressure?
Is your Body Mass Index (BMI) over 35?
Are you over 50 years old?
Is your neck circumference large? (43 cm or more for men, 41 cm or more for women)
Gender = male?

B2.2 Screening for insomia

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 anicipate that sleep problems will occur several times a week
I wake up and can't 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 sleeplessly for half an hour or more before falling asleep

B2.3 Periodic limb movement disorder and restless leg syndrome screening

Indicate which of the following statements can be applied to you:

Apart from exercising, I still feel tension in my leg muscle
I have noticed ((or someone else has noticed)) that parts of my body jerk during sleep
I have been told that I kick at night
When I try to fall asleep, I feel pain or a crawling sensation in my legs
At night, I experience pain and cramps in my legs
Sometimes at night I can't keep my legs still. I have to move them to feel comfortable
Even though I sleep at 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 Using a smartphone (optional)

Enter the average time during the day, you use your smartphone

B3.3 Motor disorders of the oral cavity and face

Have you been diagnosed with or experience symptoms of any of the following conditions?

Orofacial dyskinesia
Oromandibular dystonia
Parkinson's disease
Huntington's disease
Tourette's syndrome
Hemifascial spasm
Tardive dyskinesia

B3.4 Screening for gastroesophageal reflux

How many times a week do the following symptoms occur?

A. Burning sensation behind the sternum (heartburn)

0 days
1 day
2–3 days
4–7 days

B. Stomach contents move into throat or mouth (regurgitation of stomach contents)

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. Problems with sleeping due to heartburn or regurgitation

0 days
1 day
2–3 days
4–7 days

F. The need to use over-the-counter medications for heartburn or regurgitation

0 days
1 day
2–3 days
4–7 days

B3.5 Screening for autoimmune diseases or connective tissue diseases

Have you been diagnosed with one of the following conditions?

Rheumatoid arthritis
Lupus
Other systemic rheumatic diseases, including fibromyalgia
Other systemic diseases including systemic sclerosis, polymyalgia rheumatica, mixed connective tissue disease

B3.6 Attention deficit hyperactivity disorder

Have you been diagnosed with attention deficit hyperactivity disorder ADHD?

No
Yes

B4. Evaluation of prescription drugs and substances used – self-report

B4.1 Drugs

Mark, if you use receational or street drugs
If so, please specify what drugs you use for recreational purposes————

B4.2 Medicines

Are you currently taking any of the following medications?

Antidepressants (eg. selective serotonin reuptake inhibitors)
Benzodiazepines
Neuroleptics, antipsychotics, antiemetics (dopamine antagonists)
Drug for ADHD
Antiallergic drugs
Medical marijuana CBD
Medical marijuana THC
Opioids
Others
If so, please list all medications and dosages————

B4.3 Tobacco

Do you smoke or use any tobacco products?

No
Yes
I'm quitting
If so, how many cigarettes do you smoke per day? No————

B4.4 Alcohol

Do you consume an alcoholic beverages? (beer, wine, strong alcohol)?

No
Yes
I am quitting
If so, what is your approximate consumption of these alcoholic beverages? (glasses/day)? ————

B4.5 Soft drinks

Do you drink carbonated drinks regularly (eg. Cola – RedBull – Sprite – Fanta)?

No
Yes
I'm quitting
If so, what is your approximate consumption? (glasses/day)? ————

B4.6 Fruits and juices

Do you regularly drink juices or citrus fruit juices? (eg. lemon, orange, grapefruit)?

No
Yes
I am quitting
If so, what is your approximate consumption? (glasses/day)? ————

B4.7 Caffeine

Do you regularly drink coffee, tea or other drinks containing caffeine?

No
Yes
I'm quitting
If so, what is your approximate intake? (cups/day)? ————

B5. Assessment of additional factors

B5.1 Screening for familial occurance of bruxism

Does anyone in your family (eg. father, mother, children), suffer or have suffered from bruxism?

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

B5.2 Screening for familial tooth wear

Does anyone in your family (eg. father, mother, children), suffer from tooth wear?

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

B5.3 S*creening for familial sleep apnea OSA*

Does anyone in your family (eg. father, mother, children), suffer from sleep apnea?

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

B5.4 *Screening for familial orofacial pain*

Does any of your family members (eg. father, mother, children), suffer from non-dental facial pain?

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

B5.5 Screening for familial GERD

Does any of your family members (eg. father, mother, children), suffer from gastroesophageal reflux disease?

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