AXIS A – Assessment of the status and consequences of bruxism

Objective assessment - Self-report

A1. Report on sleep bruxism

A1.1 Question regarding sleep bruxism

How often do you clench or grind your teeth during sleep over 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 regarding sleep bruxism history

To your knowledge, have you clenched or ground your teeth during sleep in the past?

No
Yes
I don’t know

A2. **Report on awake bruxism**

A2.1 Question regarding teeth grinding while awake

How often do you grind your teeth when you are awake, considering the past month?

Never
Rarely
Sometimes
Most of the time
All of the time
I don't know

A2.1.1. Question regarding the history of teeth grinding while awake

Have you ever ground your teeth while awake in the past?

No
Yes
I don’t know

A2.2 Question regarding teeth clenching while awake

How often do you clench your teeth when you're awake, considering the past month?

Never
Rarely
Sometimes
Most of the time
All of the time
I don't know

KOMENTARZ: numer pytania powinien być chyba A2.2.1

A2.1.1. Question regarding the history of teeth clenching while awake

Have you ever clenched your teeth while awake in the past?

No
Yes
I don’t know

A2.3 Question regarding teeth contact while awake

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

Never
Rarely
Sometimes
Most of the time
All of the time
I don't know

A2.3.1 Question regarding the history of teeth contact while awake

Have you ever pressed, touched, or held your teeth together in any way other than while eating (i.e., contact between upper and lower teeth)?

No
Yes
I don’t know

A2.4 Question regarding jaw stiffening while awake

How often do you tense or maintain tension in your jaw muscles without clenching or bringing your teeth together, considering the past month?

Never
Rarely
Sometimes
Most of the time
All of the time
I don't know

A2.4.1 Question regarding the history of jaw stiffening while awake

Have you ever tensed or maintained tension in your muscles without clenching or bringing your teeth together?

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
KOMENTARZ: w numerze pytania chyba brakuje litery „A3.8”
3.8. Headache

Have you experienced headaches in the past 30 days that involved the area around the temples?

No
Yes

If so, for how many days?

Tooth wear

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

Sensitivity and/or pain
Functional problems (difficulty chewing and eating)
Deterioration in aesthetic appearance (decreased visual appeal of the teeth)
Fracturing of hard dental tissues and restorations
Speech disorders

Tinnitus

A3.10 Tinnitus

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

No
Yes

Dry mouth and drooling

A3.11 Dry mouth

Do you experience dry mouth?

Never
Occasionally
Frequently

A3.12 Drooling

Do you experience saliva loss at night?

I don't experience saliva loss at night.
Occasionally, my pillow gets wet at night.
My pillow often gets wet at night.
My pillow gets wet every night.
Both my pillow and other bedding get wet every night.

Clinical Examination-Based Assessment – Researcher's Report (For Researcher's 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 Masseter muscle hypertrophy

Indicate the presence of masseter muscle hypertrophy:

Left
Right

A5. Intraoral and extraoral tissues

A5.1 Soft tissues and bony tissues

Mark the presence of following symptoms

Linea alba	Left	Right	
Teeth marks on lips	Upper	Lower	
Teeth marks on tongue	Right	Front	Left
Tongue ulceration*	Right	Front	Left
Exostoses on the alveolar ridge	Mandible (Buccal/Lingual)	Maxilla (Buccal/Lingual/Midpalatal)	

*If there are hard, stiff and curled edges – it is an alarming sign, requiring immediate examination.

A5.2 Modified Friedman tongue position

KOMENTARZ: w tłumaczeniu różnie: łuk/łuki

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 arches visible
Category IV – With phonation/tongue depressor - uvula and palatal arches not visible

A5.3 Skeletal class (optional)

Class 1
Class 2
Class 3

A5.4 Skeletal profile (optional)

Normodivergent profile (average gonial angle)
Hypodivergent profile (low gonial angle)
Hyperdivergent profile (high gonial angle)

A6. Teeth and restorations

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
Oclusal / Incisal						
Palatal						

A.6.1.1 Tooth wear qualification*
*If stage ≥ 2 is detected during quantitative assessment, qualification is required.

Clinical symptoms indicating the influence of mechanical factors:
Worn patches, flat and shiny
Enamel and dentin wear to the same extent
Matched wear of occlusal surfaces, consistent features with antagonist teeth
Fracture of cusps or restorations
Teeth impressions on cheeks, tongue, and/or lip
Non-Caries Cervical Lesions (NCCL)
Wider than deeper Non-Caries Cervical Lesions (NCCL)
Damaged cervical surfaces of canines and premolars
Cracks within the enamel
Mandibular ridges

A6.2 Periodontal and dental examination

Indicate the number of teeth with the following symptoms

	Sekstant 1	Sekstant 2	Sekstant 3	Sekstant 4	Sekstant 5	Sekstant 6
Mobility						
Temperature sensivitiy						
Discomfort/pain while biting						

Broken tooth						

A6.3 Restorations

Indicate the number of teeth/implants with the following symptoms:

	Sextant 1	Sextant 2	Sextant 3	Sextant 4	Sextant 5	Sextant 6
Lost/damaged fillings						
Scratched restorations						
Cracked ceramics						
Loose implants						
Broken implants						
Loosening of the implant screw						

A6.4 Assessment of the occlusal splint (if the patient uses a hard resin splint)

Mark the occurrence of the following symptoms:

Occurrence of grinding marks (i.e., streaks, stripes)	Right	Front	Left
Occurrence of clenching marks (i.e., circular-shaped areas)	Right	Front	Left
Combination of grinding and clenching marks	Right	Front	Left
Cracks or perforations	Right	Front	Left

Instrument-Based Assessment

A7. Sleep Bruxism

KOMENTARZ: TA TABELKA NIE ZOSTAŁA PRZETŁUMACZONA. Moja sugestia:
Number of masseter events over 10% MVC - ilość kontrakcji powyżej 10% maksymalnego skurczu dobrowolnego
W kwestii bruxism time index oraz bruxism work index nie znalazłam żadnych rozsądnych prac tłumaczących co to za indeksy

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 SB episodes associated with awakening	
Number of SB episodes not associated with awakening	
Bruxism time index (if available)	
Bruxism work index (if available)	

A.7.3 Other methods (optional)

Smartphone application for assessing bruxism sounds

A7.4 Device with sensors (optional)

Number of events per occlusal pressure

A8. Awake bruxism

A8.1 Ecological momentary assessment – weekly report

Condition	Week 1 (%)	Additional weeks (%)
Relaxed masticatory muscles (no teeth contacts)		
Stiffening of the mandible (no teeth contacts)		
Teeth contact (gentle, constant touching)		
Teeth clenching (forceful, constant touching)		
Teeth grinding		

A8.2 Electromyography during wakefulness

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)

Unstimulated salvia pH	
Unstimulated salvia flow	
Stimulated saliva ph (paraffin)	
Stimulated saliva flow	

Axis B: Risk Factors, 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
Neutral
Describes me
Describes me very well

B2. Concurrent sleep-related conditions assessment — Self-Report

B2.1 Screening for Sleep Apnea

Mark which of the following questions you would answer "yes" to:
Do you snore loudly?
Do you often feel tired, fatigued, or sleepy during the day?
Has anyone noticed that you stop breathing, gasp, or struggle for air during sleep?
Do you have 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 Insomnia Screening

Indicate which of the following statements are true for you:

I have difficulty falling asleep
I experience racing thoughts that prevent me from falling asleep
I anticipate a problem with sleep several times a week
I wake up and cannot fall back asleep
I worry about various things and struggle to relax
I wake up in the morning earlier than I would like
I lie awake for half an hour or more before falling asleep

B2.3 Screening for Periodic Limb Movement Disorder and Restless Legs Syndrome

Indicate which of the following statements are true for you:

Other than when exercising, I still experience muscle tension in my legs
I have noticed (or someone else has noticed) that parts of my body twitch 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
Although 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 Smartphone usage (optional)

Please provide the average time per day spent using a smartphone.

B3.3 Orofacial motor disorders

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

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

B3.4 Screening for gastroesophageal reflux disease (GERD)

How many days per 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 leaks to the throat or mouth (acid regurgitation)
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. Difficulty sleeping due to heartburn or acid reflux
0 days
1 day
2-3 days
4–7 days

F. The need to use over-the-counter medication for heartburn or acid reflux
0 days
1 day
2–3 days
4–7 days

B3.5 Screening for autoimmune diseases or connective tissue disorders

Have you been diagnosed with any of the following conditions?

Rheumatoid arthritis (RA)
Lupus
Other systemic rheumatic diseases, including fibromyalgia
Other systemic conditions, including systemic sclerosis, polymyalgia rheumatica, mixed connective tissue disease (MCTD)

B3.6 Attention Deficit Hyperactivity Disorder (ADHD)

Has ADHD (Attention Deficit Hyperactivity Disorder) been diagnosed in you?

No
Yes

B4. Prescription Medications and Substances Usage Assessment – Self Report

B4.1 Drugs

Check if you use recreational or street drugs.
If yes, please specify which drugs you use recreationally_____

B4.2 Medications
Are you currently taking any of the following medications?

Antidepressants (e.g. selective serotonin reuptake inhibitors (SSRIs))
Benzodiazepines
Antipsychotics, neuroleptics, antiemetics (dopamine antagonists)
ADHD medication
Allergy medication
Medical cannabis CBD
Medical cannabis THC
Opioids
Other
If so, please list all medications and dosages_____

B4.3 Tobacco

Do you smoke or use any tobacco products?

No
Yes
Trying to quit

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

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

No
Yes
Trying to quit

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

B4.5 Non-Alcoholic Beverages
Do you regularly drink soft drinks (e.g., Coca-Cola, Red Bull, Sprite, Fanta)?

No
Yes
Trying to quit

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

B4.6 Juices and Fruits

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

No
Yes
Trying to quit

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

B4.7 Caffeine

Do you regularly drink coffee, tea, or other beverages containing caffeine?
No
Yes
Trying to quit

If yes, what is your approximate daily intake (cups/day)? _____

B5. Assessment of additional factors

B5.1 Screening for family history of bruxism

Has anyone in your family (such as your father, mother, children) suffered from or is suffering from bruxism?

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

B5.2 Screening for family history of tooth wear

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

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

B5.3 Screening for family history of obstructive sleep apnea (OSA)

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

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

B5.4 Screening for family history of orofacial pain

Does any member of your family (such as father, mother, children) suffer from facial pain unrelated to the teeth?

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

B5.5 Screening for family history of gastroesophageal reflux disease (GERD)

Does any member of your family (such as father, mother, children) suffer from gastroesophageal reflux disease (GERD)?

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