

AXIS A – Assessment of the status and consequences of bruxism

Subject Based Assessment - Self-report

A1. Sleep bruxism report

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 history of sleep bruxism

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 last 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 last month?

Never

Rarely

Sometimes

Most of the time

All of the time

I don't know

A2.2.1. 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 hold 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'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

Headache

A.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 (reduced attractiveness of teeth)

Fracturing of hard dental tissues and restorations

Phonetic disorders

Tinnitus

A3.10 Tinnitus

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

No

Yes

Xerostomia and drooling

A3.11 Xerostomia

Do you experience dry 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 at night.

My pillow often gets wet at night.

My pillow always gets wet at night.

Every night my pillow and bed linen get wet

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

Mark the presence of masseter muscle hypertrophy:

Left

Right

A5. Intra- and extraoral tissues

A5.1 Soft tissues and bone tissues

Mark the presence of following symptoms

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

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

A5.2 Modified Friedman 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 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 (medium 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
Occlusal / Incisal						
Palatal						

A.6.1.1 Tooth wear qualification*

*If a grade ≥ 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 sensivity						
Discomfort/pain while biting						
Broken teeth						

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

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 grinding 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)

Rest salivary pH	
Rest salivary flow	

Stimulated saliva ph (paraffin)	
Stimulated saliva flow	

Axis B: Risk factors and etiological factors, and comorbidities

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. Assessment of Comorbid Sleep-Related Disorders — Self-Report

B2.1 Sleep apnea screening

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 sleep problems 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 in the morning earlier than I would like

I lie awake for half an hour or longer 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:

Apart from exercising, I still feel 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

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 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's syndrome
Hemifacial spasm
Tardive dyskinesia

B3.4 Screening for gastroesophageal reflux disease (GERD)

How many times 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 move into 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. Problems with 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 regurgitation

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 one 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)

Have you been diagnosed with attention deficit hyperactivity disorder ADHD?

No

Yes

B4. Prescription Medications and Substances Usage Assessment – Self Report

B4.1 Drugs

Mark, if you use recreational or street drugs

If so, please specify what drugs you use for recreational purposes———

B4.2 Medications

Are you currently taking any of the following medications?

Antidepressants (e.g. selective serotonin reuptake inhibitors (SSRIs))
Benzodiazepines
Neuroleptics, antipsychotics, antiemetics (dopamine antagonists)
ADHD medication
Antiallergic medication
Medical marijuana CBD
Medical marijuana THC
Opioids
Others
If so, please list all the 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, strong liquor)?

No
Yes
Trying to quit

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

B4.5 Soft drinks

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 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 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