PORTUGUESE (PORTUGAL)
TRANSLATION PROJECT

STAB – Common Back Translation

Authors: João Ferreira (BT1), Francisco Vicente (BT2), André Almeida (SC2)

STAB –
Standardised Tool for the Assessment of Bruxism

Demographic Data

Sex
Male
Female
Unspecified/Other

Age	Height	Weight

Marital status:

( ) Married
( ) Cohabiting
( ) Divorced
( ) Separated
( ) Widowed
( ) Never married

What is the highest level of education you have completed?

( ) Primary Education (1st to 4th grade)
( ) Preparatory Education (5th to 9th grade)
( ) Secondary Education (10th to 12th grade)
( ) Bachelor's Degree
( ) Master's Degree
( ) Doctorate Degree
( ) Other: Which one?_____

AXIS A – ASSESSMENT OF THE CONDITION AND CONSEQUENCES OF BRUXISM

Subject Based Assessment (SBA) — Self Report

A1. SLEEP BRUXISM REPORT

A1.1 Question about sleep bruxism

Based on the last month, how often do you clench or grind your teeth while sleeping (based on any information you may have)?

( ) Never
( ) Less than one night per month
( ) 1-3 nights per month
( ) 1-3 nights per week
( ) 4-7 nights per week
( ) Do not know

A1.1.1 Sleep bruxism history question

In the past, did you used to clench or grind your teeth while sleeping (based on any information you may have)?

( ) No
( ) Yes
( ) Do not know

A2. AWAKE BRUXISM REPORT

A2.1 Awake teeth grinding question

Based on the last month, how often do you grind your teeth during waking hours?

( ) Never
( ) Rarely
( ) Sometimes
( ) Often
( ) Always
( ) Do not know

A.2.1.1 Awake teeth grinding history question

In the past, did you used to grind your teeth while awake?

( ) No
( ) Yes
( ) Do not know

A2.2 Awake teeth clenching question

Based on the last month, how often do you **clench your teeth during waking hours**?

( ) Never
( ) Rarely
( ) Sometimes
( ) Often
( ) Always
( ) Do not know

A2.2.1 Awake teeth clenching history question
In the past, did you used to clench your teeth during waking hours?

( ) No
( ) Yes
( ) I don't know

A2.3 Awake teeth contact question
Based on the last month, how often do you press, touch, or clench your teeth together, except during meals (i.e., contact between your upper and lower teeth)?

( ) Never
( ) Rarely
( ) Sometimes
( ) Often
( ) Always
( ) Do not know

A2.3.1 Awake teeth contact history question
In the past, did you often clench, grind, or keep your teeth together, except during meals (i.e., contact between upper and lower teeth)?

( ) No
( ) Yes
( ) Do not know

A2.4 Jaw clenching or tension without tooth contact while awake question

Based on the past month, how often do you feel increased muscle tension? Do you hold, clench, or tense your muscles **without clenching or grinding your teeth**?

( ) Never
( ) Rarely
( ) Sometimes
( ) Often
( ) Always
( ) Do not know

A2.4.1 History of jaw clenching or tension without dental contact while awake question
In the past, did you often hold, tighten, or tense your muscles without clenching or grinding your teeth?

( ) No
( ) Yes
( ) Do not know

A3. PATIENT COMPLAINTS

TEMPOROMANDIBULAR DYSFUNCTION

A3.1 TMD related pain

In the last 30 days, which of the following best describes any pain in your mandible or temple region, on either side?

( ) No pain
( ) Pain comes and goes
( ) Pain is always present

A3.2 Pain or stiffness upon waking up

In the last 30 days, have you experienced pain or stiffness in your mandible upon waking up?

( ) No
( ) Yes

A3.3 Closed mouth block

In the last 30 days, have you felt your jaw lock up or get stuck, even for a moment, so that you couldn't open it FULLY?

( ) No
( ) Yes

A3.4 Change in pain with activities

In the past 30 days, have the following activities changed any pain (i.e., made it better or worse) in your jaw, at the base of your skull, in your ear, or in front of your ear on either side?

A. Chewing hard or tough food
( ) No
( ) Yes

B. Open your mouth or move your mandible forward or to the side
( ) No
( ) Yes

C. Habits involving the jaws, such as clenching the teeth, grinding the teeth, or chewing gum
( ) No
( ) Yes

D. Other jaw activities such as talking, kissing, or yawning
( ) No
( ) Yes

A3.5 Articular sounds

In the last 30 days, have you heard any clicking sound(s) in your jaw joint when you moved or used your jaw?

( ) No
( ) Yes

A3.6 Muscle pain during wakefulness

In the last 30 days, have you experienced muscle pain in your jaws during any of the following times of day?

( ) Between waking up and taking breakfast
( ) Between breakfast and lunch

( ) Between lunch and dinner
( ) Between dinner and bedtime

A3.6.1 Muscle tiredness or fatigue while awake
In the last 30 days, have you experienced stiffness or a feeling of tension, muscle tiredness, or fatigue in your jaw during any of the following times of the day?

( ) Between waking up and taking breakfast
( ) Between breakfast and lunch
( ) Between lunch and dinner
( ) Between dinner and bedtime

A3.7 Symptoms upon waking up question

Are you aware of any of the following symptoms when you wake up?

( ) Feeling of fatigue, pain, or stiffness in the jaws
( ) Feeling that your teeth are clenched or that your mouth is sore
( ) Pain in the temples
( ) Feeling of tension in the jaw joint upon waking and feeling that you have to move your lower jaw to release it
( ) Difficulty opening your mouth wide when you wake up
( ) Hearing or feeling a clicking sound in your jaw joint when you wake up that disappears afterwards

HEADACHE

A3.8 HEADACHE
In the past 30 days, have you had any headaches that included the temporal areas of your head?

( ) No
( ) Yes
If yes, 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 of aesthetic appearance (compromised dental attractiveness)
( ) Destruction of hard dental tissue and restorations
( ) Phonetic impairment

TINNITUS

A3.10 TINNITUS
Do you have noise or ringing in your ears (tinnitus)?

( ) No
( ) Yes

XEROSTOMIA AND SALIVATION

A3.11 Xerostomia
Does your mouth feel dry?

( ) Never
( ) Occasionally
( ) Often

A3.12 Salivation

Do you experience loss of saliva during sleep?

( ) I never experience loss of saliva (drooling) during sleep
( ) My pillow sometimes gets wet during sleep
( ) My pillow regularly gets wet during sleep
( ) My pillow gets wet every day during sleep
( ) Every night, my pillow and other bedding get wet

Clinical Based Assessment (CBA) – Examiner's Report

(for the examiner's use)

A4. JOINTS AND MUSCLES

A4.1 TMD diagnosis (optional item)
Mark the presence of the following diagnoses

A4.1.1. Pain disorders*
* Complete this section only if item A3.3 (Pain Screening Questionnaire - TMD) has been answered positively by the patient.

( ) Myalgia
( ) Widespread myofascial pain
( ) Myofascial pain with referred radiation
( ) Right arthralgia
( ) Left arthralgia
( ) Headache attributed to TMD

A4.1.2. Right TMJ disorders*
*Specify whether the diagnosis is based on a clinical and/or imaging assessment.

( ) Disc displacement with reduction
( ) Disc displacement with reduction, with intermittent locking
( ) Disc displacement without reduction with opening limitation
( ) Disc displacement without reduction without opening limitation
( ) Degenerative joint disease
( ) Subluxation

A4.1.3. Left TMJ disorders*

*Specify whether the diagnosis is based on clinical and/or imaging evaluation.

( ) Disc displacement with reduction
( ) Disc displacement with reduction, with intermittent locking
( ) Disc displacement without reduction with opening limitation
( ) Disc displacement without reduction without opening limitation
( ) Degenerative joint disease
( ) Subluxation

A4.2 Masseter muscle hypertrophy

Mark the presence of masseter hypertrophy

( ) Left
( ) Right

A5. INTRA- AND EXTRAORAL TISSUES

A5.1 Soft and bone tissues

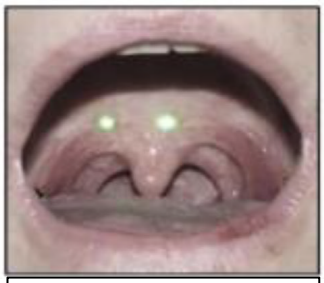
Mark the presence of the following signs by circling the corresponding answer:

Linea Alba	Left	Right	
Lip edentations	Upper	Lower	
Edentated tongue	Right	Front	Left
Tongue ulcerations*	Right	Front	Left
Alveolar bone exostoses	Mandible (buccal/lingual)	Maxilla (buccal/palatal/mid palatal)	

*If positive and has firm, hardened, raised edges – red alert for urgent further investigation.

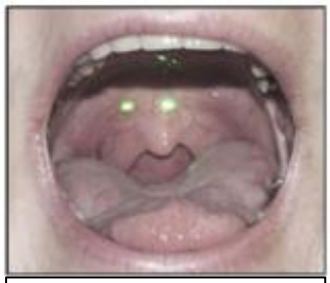
A5.2 Tongue position – Modified Friedman classification

After intraoral assessment, mark the respective category.



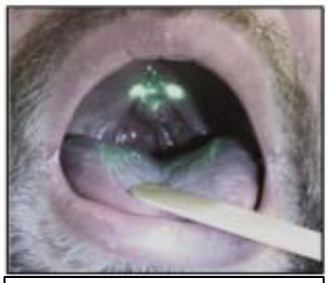
Category I: Absence of phonation or lingual depressor – visible uvula and palatal arch

( )



Category II: With phonation – uvula and palatal arch visible

( )



Category III: With tongue depressor – uvula and palatal arch visible

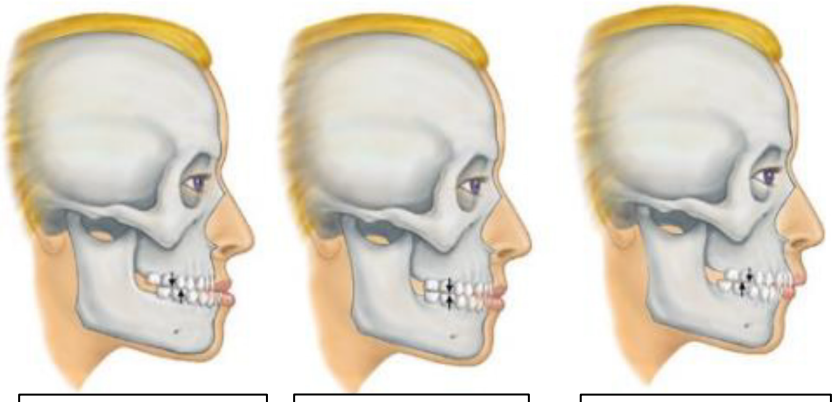
( )

Category IV: With phonation or lingual depressor – uvula and palatal arch not visible

( )

A5.3 Skeletal class (optional item)

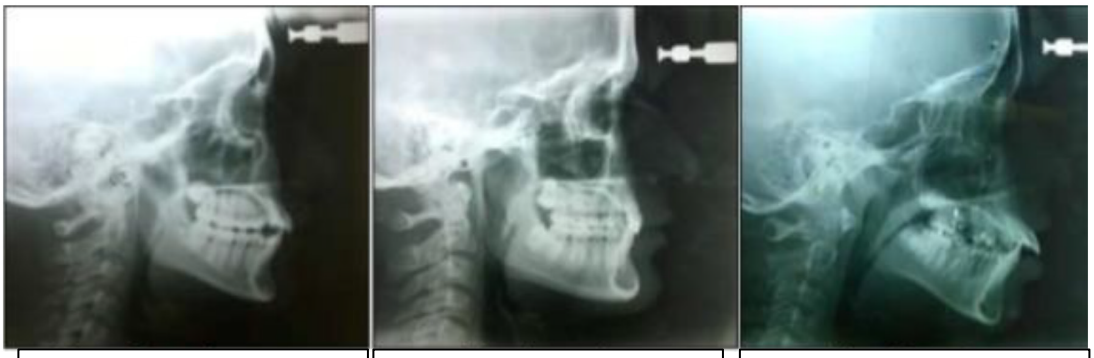
( ) Class I
( ) Class II
( ) Class III



Class III Skeletal Facial Profile | Class I Skeletal Facial Profile | Class II Skeletal Facial Profile

A5.4 Skeletal profile (optional item)

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



Normodivergent | Hypodivergent | Hyperdivergent

A6. TEETH AND RESTORATIONS

A6.1 Screening for tooth wear – quantification

a. Occlusal/incisal wear by sextant

(0) no visible wear

(1) visible wear within the enamel

(2) visible wear with exposure of dentine and loss of clinical crown height of ≤1/3

(3) loss of crown height >1/3 but <2/3

(4) loss of crown height ≥2/3

b. Palatal wear in the 2nd sextant

(0) no visible wear, (1) wear confined to enamel, (2) wear on dentine

1st Sextant - Occlusal	2nd Sextant - Incisal	3rd Sextant - Occlusal
0 1 2 3 4	0 1 2 3 4	0 1 2 3 4
	2nd Sextant - Palatal	
	0 1 2	
6th Sextante - Occlusal	5th Sextant - Incisal	4th Sextant - Occlusal
0 1 2 3 4	0 1 2 3 4	0 1 2 3 4

A.6.1.1 Tooth wear qualification*

*When a score of ≥ 2 is detected during quantification, qualification is required..

Clinical signs indicating the influence of mechanical factors:
Shiny, flat, polished facets
Enamel and dentine wear at the same rate
Wear on corresponding occlusal surfaces, characteristic of antagonist teeth
Fractured cusps or restorations
Indentations/trauma to the cheek, tongue and/or lip
Non-carious cervical lesions located in the cervical areas of the teeth (NCCL)
Vestibular/cervical lesions that are wider than they are deep, non-carious cervical lesions (NCCL)
The cervical areas of the premolars and cusps are affected
Enamel fissures
Mandibular torus

a. The dental wear observed is:

☐ mainly mechanical

☐ mainly chemical

☐ mechanical e chemical

A6.2 Periodontal and Dental Examination

Indicate the number of the tooth that shows the following signs:

	1st Sextant	2nd Sextant	3rd Sextant	4th Sextant	5th Sextant	6th Sextant
Tooth mobility						
Thermal sensitivity						
Discomfort/pain when biting						
Fractured teeth						

A6.3 Restorations

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

	1st Sextant	2nd Sextant	3rd Sextant	4th Sextant	5th Sextant	6th Sextant
Loss/fracture of restorations						
Abraded/worn restorations						
Ceramic fracture (shipping)						
Implant mobility						
Implant fracture						
Fracture/loosening of implant restoration screws						

A6.4 Assessment of intraoral device (if patient uses hard acrylic resin occlusal splint)

Mark the presence of the following signs

	Right	Anterior zone	Left
Prevalence of grinding marks (horizontal stripes, etc.)			
Prevalence of clenching marks (circular indentations in the acrylic, etc.)			
Combination of grinding and clenching marks			
Fractures or perforations			

ASSESSMENT BASED ON TECHNOLOGICAL INSTRUMENTAL INFORMATION

A7. SLEEP BRUXISM

A7.1 Electromyography

Number of masseter events above 10% MVC (maximum voluntary contraction): _____

Bruxism time index (if available):_____

Bruxism work/behaviour index (if available):_____

Example of grinding marks

Example of clench marks

Example of combined marks

A7.2 Polysomnography (optional)

Number of micro-awakenings related to SB:_____

Number of micro-awakenings unrelated to SB:_____

Bruxism time index (if available):_____

Bruxism work/behaviour index (if available):_____

A7.3 Other methods (optional)
Smartphone application score for sounds associated with teeth grinding:_____

A7.4 Device with sensors (optional)
Number of pressure increase events associated with teeth clenching:_____

A8. AWAKE BRUXISM

A8.1 Ecological momentary assessment – one week monitoring report

Condition	1 week (in %)	Additional week(s) (in %)
Relaxed jaw muscles (no tooth contact)		
Muscle tension and feeling of pushing the jaw (no tooth contact)		
Tooth contact (light and constant touch)		
Teeth clenching (strong and constant touch)		
Teeth grinding		

A8.2 Electromyography during wakefulness

Number of masseter events above 10% MVC (maximum voluntary contraction): _____
Bruxism time index (if available):_____
Bruxism work/behaviour index (if available):_____

A9. ADDITIONAL INSTRUMENTS

A9.1. Intraoral acidity (optional)
Salivary pH at rest: _____
Salivary flow at rest: _____
Stimulated salivary pH (paraffin): _____
Stimulated salivary flow: _____

AXIS B – ETIOLOGICAL RISK FACTORS AND ASSOCIATED COMORBIDITIES[JF1]

B1. PSYCHOSOCIAL ASSESSMENT — SELF-REPORT

OROFACIAL PAIN, TEMPOROMANDIBULAR DYSFUNCTION, BRUXISM AND SLEEP

B1.1 Anxiety and depression screening

In the last two weeks, how often have you been bothered by any of the following problems?

1. Feeling nervous, anxious, or on edge
   - ( ) Never
   - ( ) Several days
   - ( ) More than half the days
   - ( ) Almost every day

2. Not being able to stop or control worrying
   - ( ) Never
   - ( ) Several days
   - ( ) More than half the days
   - ( ) Almost every day

3. Little interest or pleasure in doing things
   - ( ) Never
   - ( ) Several days
   - ( ) More than half the days
   - ( ) Almost every day

4. Feeling low, depressed, or hopeless
   - ( ) Never
   - ( ) Several days
   - ( ) More than half the days
   - ( ) Almost every day

B1.2 *Coping*

Consider how well the following statements describe your behaviours and actions

1. I look for creative ways to change 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 that I can control my reaction:
   - ( ) Does not describe me at all
   - ( ) Does not describe me
   - ( ) Neutral
   - ( ) Describes me
   - ( ) Describes me very well

3. I believe that I can grow in a positive way when dealing with difficult situations
   ( ) Does not describe me at all
   ( ) Does not describe me
   ( ) Neutral
   ( ) Describes me
   ( ) Describes me very well

4. I actively seek ways to make up for 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 CONCOMITANT SLEEP-RELATED CONDITIONS – SELF-REPORT

B2.1 Sleep apnea screening

Please tick the following questions to which you answer affirmatively:

( ) Do you snore loudly?
( ) Do you often feel tired, fatigued, or sleepy during the day?
( ) Has anyone ever noticed that you stop breathing or gasp for air during sleep?
( ) Do you have, or are you being treated for, high blood pressure?
( ) Do you have a body mass index greater than 35 (weight/height2)?
( ) Are you over 50 years of age?
( ) Do you have a large neck circumference (43 cm or greater for men; 41 cm or greater for women)?
( ) Are you male?

B2.2 Insomnia screening

Please tick the following questions to which you answer affirmatively:

( ) I have difficulty falling asleep
( ) Thoughts run through my mind and prevent me from sleeping
( ) I anticipate a problem during sleep several times a week
( ) I wake up and cannot get back to sleep
( ) I worry about things and have trouble relaxing
( ) I wake up earlier than I would like
( ) I lie awake for half an hour or more before falling asleep

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

Indicate which of the following conditions apply to you?

( ) Except when related to physical exercise, I continue to feel muscle tension in my legs
( ) I have noticed (or others have commented) that parts of my body make involuntary movements during sleep.
( ) I have been told that I kick during sleep
( ) When trying to sleep, I feel pain or numbness in my legs
( ) I experience leg pain and cramps during sleep
( ) Sometimes I cannot keep my legs still during sleep. I have to move them to feel comfortable
( ) Although I slept during the sleep period, I feel sleepy during the waking period (awake).

B2.4 Oral behaviours – position during sleep

Based on the last month, how often do you sleep in a position that puts pressure on your jaw?

( ) Never
( ) Rarely
( ) Sometimes
( ) Often
( ) Always
( ) Do not know

B3. APPROACH TO CONCOMITANT CLINICAL CONDITIONS NOT RELATED TO SLEEP – SELF-REPORT

B3.1 Oral behaviours – activities during waking hours

Based on your last month, how often do you do each of the following activities?

	Atividades durante o dia	Nenhuma vez	Um pouco do tempo	Algum do tempo	A maior parte do tempo	Todo o tempo
7.	Mantém ou projeta a mandíbula para a frente ou para o lado	☐	☐	☐	☐	☐
8.	Pressiona com força a língua contra os dentes	☐	☐	☐	☐	☐
9.	Coloca a língua entre os dentes	☐	☐	☐	☐	☐
10.	Morde, mastiga ou brinca com a sua língua, bochechas ou lábios	☐	☐	☐	☐	☐
11.	Mantém a mandíbula numa posição rígida ou tensa, como se fosse preparar para um impacto ou proteger a mandíbula	☐	☐	☐	☐	☐
12.	Mantém entre os dentes ou morde objetos, tais como, cabelo, cachimbo, lápis, canetas, dedos, unhas, etc.	☐	☐	☐	☐	☐
13.	Utiliza pastilha elástica	☐	☐	☐	☐	☐
14.	Toca instrumento musical que envolva o uso da boca ou mandíbula (por exemplo, instrumentos de sopro, metal ou madeira, ou instrumentos de corda)	☐	☐	☐	☐	☐
15.	Inclina-se com a mandíbula sobre a sua mão, por exemplo, em concha ou a descansar o queixo na mão	☐	☐	☐	☐	☐
16.	Mastiga a comida só de um lado	☐	☐	☐	☐	☐
17.	Come entre refeições (isto é, comida que requeira mastigação)	☐	☐	☐	☐	☐
18.	Fala durante períodos prolongados (por exemplo, ensina, vende, apoio ao consumidor)	☐	☐	☐	☐	☐
19.	Canta	☐	☐	☐	☐	☐
20.	Boceja	☐	☐	☐	☐	☐
21.	Segura o telefone entre a sua cabeça e os ombros	☐	☐	☐	☐	☐

B3.2 Use of smartphones ~~Smartphone use~~ or other electronic devices~~appliances~~ (optional item)

Indicate the average time per day, in hours, that you use your~~of~~ smartphone ~~use~~ or other electronic devices: _____ ~~appliances: _____~~ h

B3.3 Orofacial motor disorders

Have you been diagnosed with or suffer from possible signs of any of the following conditions?

( ) Orofacial dyskinesia
( ) Oromandibular dystonia
( ) Parkinson's disease
( ) Huntington's disease
( ) Tourette syndrome
( ) Hemifacial spasms
( ) Tardive dyskinesia

B3.4 Screening for gastro-oesophageal reflux disease

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

A. Burning sensation behind the breastbone (heartburn)

( ) 0 Days
( ) 1 Day
( ) 2–3 Days
( ) 4–7 Days

B. Stomach contents rising into the throat or mouth (reflux)

( ) 0 Days
( ) 1 Day
( ) 2–3 Days
( ) 4–7 Days

C. Pain in the middle or upper part of the stomach

( ) 0 Days
( ) 1 Day
( ) 2–3 Days

( ) 4–7 Days

D. Nausea
( ) 0 Days
( ) 1 Day
( ) 2–3 Days
( ) 4–7 Days

E. Difficulty getting a good night's sleep due to heartburn or reflux
( ) 0 Days
( ) 1 Day
( ) 2–3 Days
( ) 4–7 Days

F. Need to use medication for heartburn or reflux
( ) 0 Days
( ) 1 Day
( ) 2–3 Days
( ) 4–7 Days

B3.5 Screening for autoimmune or connective tissue diseases

Have you been diagnosed with any of the following conditions?

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

B3.6 Attention Deficit Hyperactivity Disorder

Have you been diagnosed with Attention Deficit Hyperactivity Disorder?
( ) No
( ) Yes

B4. PRESCRIBED MEDICATIONS AND SUBSTANCE USE ASSESSMENT — SELF-REPORT

B4.1 Drugs

Do you use recreational drugs or illicit drugs?
( ) No
( ) Yes

If so, please indicate which drugs you use: _____

B4.2 Medications

Are you currently taking any of the following medications?

( ) Antidepressants (e.g., selective serotonin reuptake inhibitors)
( ) Benzodiazepines
( ) Neuroleptics, antipsychotics, antiemetics (dopamine antagonists)
( ) Medication for ADHD
( ) Antiallergic medication
( ) Medical marijuana CBD
( ) Medical marijuana TSH
( ) Opiates
( ) Others

If you have ticked any of the above, please list the names of all medicines and their dosages:

_____

_____

_____

B4.3 Tobacco

Do you smoke or use any tobacco products?

( ) No
( ) Yes
( ) Occasionally

If so, how many cigarettes do you smoke per day? No.:_____

B4.4 Alcohol

Do you consume alcoholic beverages (beer, wine, spirits, etc.)?

( ) No
( ) Yes
( ) Occasionally

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

B4.5 Soft drinks

Do you regularly consume carbonated drinks (Coca-Cola, Red Bull, Fanta, Sprite, other soft drinks, etc.)?

( ) No
( ) Yes
( ) Occasionally

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

B4.6 Juices and fruits

Do you regularly drink juice or consume citrus fruits (e.g. lemon, orange, grapefruit)?

( ) No
( ) Yes
( ) Occasionally

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

B4.7 Caffeine

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

( ) No
( ) Yes
( ) Occasionally

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

B5. ASSESSMENT OF ADDITIONAL FACTORS

B5.1 Family bruxism screening

Do you know anyone in your family (e.g., father, mother, children) who has a history of bruxism?

( ) No
( ) Yes Father/Mother/Son/Daughter/Grandfather/Grandmother
( ) Don't know

B5.2 Family dental wear screening

Do you know anyone in your family (e.g., father, mother, children) who has tooth wear?

( ) No
( ) Yes Father/Mother/Son/Daughter/Grandfather/Grandmother
( ) Don't know

B5.3 Family obstructive sleep apnea screening

Do you know anyone in your family (e.g., father, mother, children) who has sleep apnea?

( ) No
( ) Yes Father/Mother/Son/Daughter/Grandfather/Grandmother
( ) Don't know

B5.4 Family orofacial pain screening

Do you know anyone in your family (e.g., father, mother, children) who has non-dental orofacial pain?

( ) No

( ) Yes Father/Mother/Son/Daughter/Grandfather/Grandmother
( ) Don't know

B5.5 Family GERD screening

Do you know anyone in your family (e.g., father, mother, children) who has gastroesophageal reflux disease?

( ) No
( ) Yes Father/Mother/Son/Daughter/Grandfather/Grandmother
( ) Don't know