Bruxism Screening Questionnaire

Full Name

Age

Email

1. Do you grind or clench your teeth during the day or night?

- Yes
- No

2. Has anyone told you that you grind your teeth while sleeping?

- Yes
- No

3. Do you frequently wake up with jaw pain or stiffness?

- Yes
- No

4. Have you experienced headaches after waking up?

- Yes
- No

5. Do you have damaged or worn-down teeth?

- Yes
- No

6. Do you experience tension or soreness in your jaw muscles?

- Yes
- No

7. Do you have difficulty opening or closing your mouth?

- Yes
- No

Additional Notes