

OCCLUSAL SCREENING QUESTIONNAIRE

	Yes	No
Do you clench or grind your teeth during the day?	<input type="checkbox"/>	<input type="checkbox"/>
Have you been made aware of clenching or grinding your teeth during the night?	<input type="checkbox"/>	<input type="checkbox"/>
Do you often wake up during the night?	<input type="checkbox"/>	<input type="checkbox"/>
Are your jaws or teeth tired when you wake in the morning?	<input type="checkbox"/>	<input type="checkbox"/>
Do you feel refreshed when you wake in the morning?	<input type="checkbox"/>	<input type="checkbox"/>
Do you suffer from chronic headaches or neck and shoulder pains?	<input type="checkbox"/>	<input type="checkbox"/>
Do you now, or have you ever had, pain in your jaw joint or the sides of your face, particularly around the ear?	<input type="checkbox"/>	<input type="checkbox"/>
Have your jaws ever clicked or popped when you open your mouth?	<input type="checkbox"/>	<input type="checkbox"/>
Have your jaws ever locked open or closed?	<input type="checkbox"/>	<input type="checkbox"/>
Do you tend to chew on only one side of your mouth?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had any dental work (crowns, bridges, fillings etc.) that stopped your teeth biting normally together or felt "in the way"?	<input type="checkbox"/>	<input type="checkbox"/>
Were you referred to this practice?	<input type="checkbox"/>	<input type="checkbox"/>

If yes, by whom?.....

