NEW FARM DENTAL STUDIO.COM.AU

Occlusal Screening Questionnaire

Patient name: _____

Dentist name: _____

Date: 06-Aug-2017

	YES	NO
Do you clench or grind your teeth during the day?	○	○
Have you been made aware of clenching or grinding your teeth during the night?	○	○
Do you often wake up during the night?	○	○
Are your jaws or teeth tired when you wake in the morning?	○	○
Do you feel refreshed when you wake in the morning?	○	○
Do you suffer from chronic headaches, or neck and shoulder pain?	○	○
Do you now, or have you ever had pain in your jaw joint or the sides of your face particularly around the ear?	○	○
Have your jaws ever clicked or locked opened or closed?	○	○
Do you tend to chew on only one side of your mouth?	○	○
Have you ever had any dental work (crowns, bridges, fillings, etc) that stopped your teeth biting normally together or felt “in the way”?	○	○

Check Form