# OCCLUSAL SCREENING

| | YES | NO |
|---|---|---|
| 1. Do you clench or grind your teeth during the day? | ____ | ____ |
| 2. Have you been made aware of clenching or grinding your teeth during sleep? | ____ | ____ |
| 3. Do you have chronic headaches, neck, or shoulder pain? | ____ | ____ |
| 4. Are your teeth or jaws tired when you awaken? | ____ | ____ |
| 5. Have you ever had pain in your jaw joints, sides of your face, or ears? | ____ | ____ |
| 6. Have your jaws ever clicked or popped when you open your mouth? | ____ | ____ |
| 7. Have you ever experienced difficulty moving your jaw or opening your mouth wide? | ____ | ____ |
| 8. Do you chew on only one side of your mouth? | ____ | ____ |