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 every experienced difficulty in moving your jaw or opening your mouth wide?	☐	☐
8. Do you chew on only one side of your mouth?	☐	☐