Dizziness Handicap Inventory

Patient's Name: _____ **Date:** _____

Instructions: The purpose of this scale is to identify difficulties that you may be experiencing because of your dizziness or unsteadiness. Please answer "Yes, "No" or "Sometimes" to each question. ***Answer each euestion as it applies to your dizziness or unsteadiness only.***

Please put a "√" in the appropriate space.	**Yes**	**No**	**Sometimes**
1. Does looking up increase your problem?			
2. Because of your problem, do you feel frustrated?			
3. Because of your problem, do you restrict your travel for business or recreation?			
4. Does walking down the aisle of a supermarket increase your problem?			
5. Because of your problem, do you have difficulty getting into your bed?			
6. Does your problem significantly restrict your participation in social activities such as going out to dinner, going to the movies, dancing, or to parties?			
7. Because of your problem, do you have difficulty reading?			
8. Does performing more ambitious activities like sports, dancing, household chores such as sweeping or putting dishes away increase your problem?			
9. Because of your problem, are you afraid to leave your home without having someone accompany you?			
10. Because of your problem, have you been embarrassed in front of others?			
11. Does quick movement of your head increase your problem?			
12. Because of your problem, do you avoid heights?			
13. Does turning over in bed increase your problem?			
14. Because of your problem, is it difficult to do strenuous housework or yard work?			
15. Because of your problem, are you afraid people may think that you are intoxicated?			
16. Because of your problem, is it difficult for you to go for a walk by yourself?			
17. Does walking down a sidewalk increase your problem?			
18. Because of your problem, is it difficult for you to concentrate?			
19. Because of your problem, is it difficult for you to walk around the house in the dark?			
20. Because of your problem, are you afraid to stay home alone?			
21. Because of your problem, do you feel handicapped?			
22. Has your problem placed stress on your relationships with members of your family or friends?			
23. Because of your problem, are you depressed?			
24. Does your problem interfere with your job or household responsibilities?			
25. Does bending over increase your problem?			
Sub-Total			
	x4	x0	x2
Column Totals			

DHI GRAND TOTAL: _____

P _____ E _____ F _____

( ) 100-70 = Servere perception of having a handicap ( ) 69-40 = moderate perception of handicap

( ) 39 = low perception of handicap