

# DIZZINESS HANDICAP INVENTORY

Name: \_\_\_\_\_ Date: \_\_\_\_\_

## Part I

**Instructions:** The purpose of this scale is to identify difficulties that you may be experiencing because of your dizziness or unsteadiness. Please indicate answer by circling “yes or “no” or “sometimes” for each question. Answer each question as it pertains to your dizziness or unsteadiness problem only.

- |  |     |    |           |
|--|-----|----|-----------|
| P1. Does looking up increase your problem?   | Yes | No | Sometimes |
| E2. Because of your problem, do you feel frustrated?   | Yes | No | Sometimes |
| F3. Because of your problem, do you restrict your travel for business or recreation?   | Yes | No | Sometimes |
| P4. Does walking down the aisle of a supermarket increase your problem?  | Yes | No | Sometimes |
| F5. Because of your problem, do you have difficulty getting into or out of bed?  | Yes | No | Sometimes |
| F6. Does your problem significantly restrict your participation in social activities such as going out to dinner, going to the movies, dancing, or to parties? | Yes | No | Sometimes |
| F7. Because of your problem, do you have difficulty reading?   | Yes | No | Sometimes |
| P8. Does performing more ambitious activities like sports, dancing, household chores such as sweeping or putting away dishes increase your problem?            | Yes | No | Sometimes |
| E9. Because of your problem, are you afraid to leave your home without having someone accompany you?   | Yes | No | Sometimes |
| E10. Because of your problem, have you been embarrassed in front of others   | Yes | No | Sometimes |
| P11. Do quick movements of your head increase your problem?  | Yes | No | Sometimes |
| F12. Because of your problem, do you avoid heights?  | Yes | No | Sometimes |
| P13. Does turning over in bed increase your problem?   | Yes | No | Sometimes |
| F14. Because of your problem, is it difficult for you to do strenuous housework or yard work?  | Yes | No | Sometimes |
| E15. Because of your problem, are you afraid people might think you are intoxicated?   | Yes | No | Sometimes |
| F16. Because of your problem, is it difficult for you to go for a walk by yourself?  | Yes | No | Sometimes |
| P17. Does walking down a sidewalk increase your problem?   | Yes | No | Sometimes |
| E18. Because of your problem, is it difficult for you to concentrate?  | Yes | No | Sometimes |

- F19. Because of your problem, is it difficult for you walk around the house in the dark?    Yes    No    Sometimes
- E20. Because of your problem, are you afraid to stay home alone?    Yes    No    Sometimes
- E21. Because of your problem, do you feel handicapped?    Yes    No    Sometimes
- E22. Has your problem placed stress on your relationships with members of your family or friends?    Yes    No    Sometimes
- E23. Because of your problem, are you depressed?    Yes    No    Sometimes
- F24. Does your problem interfere with your job or household responsibilities?    Yes    No    Sometimes
- P25. Does bending over increase your problem?    Yes    No    Sometimes

**Part II**

**Instructions:** Put a check in the box that best describes you.

<input type="checkbox"/>	Negligible symptoms (0)
<input type="checkbox"/>	Bothersome symptoms (1)
<input type="checkbox"/>	Performs usual work duties but symptoms interfere with outside activities (2)
<input type="checkbox"/>	Symptoms disrupt performance of both usual work duties and outside activities (3)
<input type="checkbox"/>	Currently on medical leave or had to change jobs because of symptoms (4)
<input type="checkbox"/>	Unable to work for over one year or established permanent disability with compensation payments (5)

 **STOP HERE**

Yes	Sometimes	No	
P(7) _____	x4=_____	+ _____	x2=_____ + _____ x0=_____ <b>Physical Items</b> _____ (28)
E(9) _____	x4=_____	+ _____	x2=_____ + _____ x0=_____ <b>Emotional Items</b> _____ (36)
F(9) _____	x4=_____	+ _____	x2=_____ + _____ x0=_____ <b>Functional Items</b> _____ (36)
			<b>TOTAL</b> _____ (max 100 pts)