Name:_____ Date:_____

Dizziness Handicap Inventory

Instructions: The purpose of this questionnaire is to identify difficulties that you may be experiencing because of your dizziness. Please answer every question (Y=Yes, N=No, S=Sometimes)

Item	Question		Y	N	S
1	Does looking up increase your problem?	P			
2	Because of your problem, do you feel frustrated?	E			
3	Because of your problem, do you restrict your travel for business or recreation?	F			
4	Does walking down the aisle of a supermarket increase your problems?	P			
5	Because of your problem, do you have difficulty getting into or out of bed?	F			
6	Does your problem significantly restrict your participation in social activities, such as going out to dinner, going to the movies, dancing, or going to parties?	F			
7	Because of your problem, do you have difficulty reading?	F			
8	Does performing more ambitious activities such as sports, dancing, household chores (sweeping or putting dishes away) increase your problems?	P			
9	Because of your problem, are you afraid to leave your home without having someone accompany you?	E			
10	Because of your problem have you been embarrassed in front of others?	E			
11	Do quick movements of your head increase your problem?	P			
12	Because of your problem, do you avoid heights?	F			
13	Does turning over in bed increase your problem?	P			
14	Because of your problem, is it difficult for you to do strenuous homework or yardwork?	F			
15	Because of your problem, are you afraid people may think you are intoxicated?	E			
16	Because of your problem, is it difficult for you to go for a walk by yourself?	F			
17	Does walking down a sidewalk increase your problem?	P			
18	Because of your problem, is it difficult for you to concentrate?	E			
19	Because of your problem, is it difficult for you to walk around your house in the dark?	F			
20	Because of your problem, are you afraid to stay home alone?	E			
21	Because of your problem, do you feel handicapped?	E			
22	Has the problem placed stress on your relationships with members of your family or friends?	E			
23	Because of your problem, are you depressed?	E			
24	Does your problem interfere with your job or household responsibilities?	F			
25	Does bending over increase your problem?	P			
	TOTALS		X4	X0	X2
	P/28	P			
	E/36	E			
	F/36	F			
	SUM/100=				

100-70 = severe perception of handicap, 69-40 = moderate perception of handicap, 39-0 = low perception of handicap

Dr. G.P. Jacobson, C.W. Newman, 1990