Name:_____ DOB:_____ 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. Please do not skip any questions.

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

Clinician Signature:_____ Total: _____