Bodies in Balance Physical Therapy Dizziness Handicap Inventory (DHI)

Name: _____

The purpose of this scale is to identify difficulties that you may be experiencing because of your dizziness. Please **CIRCLE** "always" OR "no" OR "sometimes" to each question as it pertains to your dizziness problem.

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