Dizziness Handicap Inventory

Patient Name:____ Date:________________

Instructions: The purpose of this scale is to identify difficulties that you may be experiencing because of your dizziness or unsteadiness.

To each question below, please place an "X" in the corresponding column: **Yes, No, Sometimes.**

An answer of "Yes" is 100% of the time, "No" is 0% of the time, and "Sometimes" 1%-99% of the time.

Answer each question as it pertains to your dizziness or unsteadiness problem only.

	Yes	No	Some-times	
1) Does looking up increase your problem?				P
2) Does walking down the aisles of a supermarket without a cart increase your problem?				P
3) Does performing more ambitious activities like sports, dancing, or household chores increase your problem?				P
4) Do quick head movements increase your problem?				P
5) Does turning over in bed increase your problem?				P
6) Does walking on the lawn increase your problem?				P
7) Does bending over increase your problem?				P
8) Because of your problem, do you restrict your travel for business or recreation?				F
9) Because of your problem, do you have difficulty getting into or out of bed?				F
10) Does your problem significantly restrict your participation in social activities?				F
11) Because of your problem, do you have difficulty reading?				F
12) Because of your problem, do you have someone accompany you when you leave home?				F
13) Because of your problem, is it difficult for you to take care of yourself (i.e. bathe, dress, prepare a meal)?				F
14) Because of your problem, is it difficult for you to walk around your house in the dark?				F
15) Because of your problem, do you avoid driving your car in the daytime?				F
16) Because of your problem, is it difficulty for you to go for a walk by yourself?				F
17) Because of your problem, is it difficulty for you to walk up and down stairs?				F
18) Because of your problem, do you avoid driving your car in the dark?				F
19) Does your problem interfere with your job or household responsibilities?				F
20) Because of your problem, is it difficult for you to concentrate?				E
21) Because of your problem, do you feel frustrated?				E

22) Because of your problem, are you afraid to stay home alone?				E
23) Because of your problem, are you afraid people think you are intoxicated?				E
24) Has your problem placed stress on your relationship with members of your family or friends?				E
25) Because of your problem, are you depressed?				E
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	x 4	x 0	x 2	
=				
Total				
☐ 100 – 70 = Severe perception of handicap				
☐ 69 – 40 = Moderate perception of handicap				
☐ 39 – 0 = Low perception of handicap				
☐ >60 = Increased fall risk				

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	Yes	No	Sometimes	Total
P	(x4)=	(x0)=	(x2)=	
F	(x4)=	(x0)=	(x2)=	
E	(x4)=	(x0)=	(x2)=	