DIZZINESS HANDICAP INVENTORY

Name:_____ **Date:** _____

Please rate your pain level with activity: **NO PAIN = 0 1 2 3 4 5 6 7 8 9 10 = VERY SEVERE PAIN**

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 and unsteadiness problem only.

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

Put a check in the box that best describes you:

- □ Negligible symptoms
- □ Bothersome symptoms
- □ Performs usual work duties but symptoms interfere with outside activities
- □ Symptoms disrupt performance of both usual work duties and outside activities
- □ Currently on medical leave or had to change jobs because of symptoms
- □ Unable to work for over one year or established permanent disability with compensation payments