NAME: ___________________________ **DATE: __________**

DIZZINESS HANDICAP INVENTORY (DHI)

Select the appropriate statements.

1. Does looking up increase your problem?
- o No
- o Sometimes
- o Yes

2. Because of your problem, do you feel frustrated?
- o No
- o Sometimes
- o Yes

3. Because of your problem, do you restrict your travel for business or recreation?
- o No
- o Sometimes
- o Yes

4. Does walking down the aisle of a supermarket increase your problems?
- o No
- o Sometimes
- o Yes

5. Because of your problem, do you have difficulty getting into or out of bed?
- o No
- o Sometimes
- o Yes

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?
- o No
- o Sometimes
- o Yes

7. Because of your problem, do you have difficulty reading?
- o No
- o Sometimes
- o Yes

8. Does performing more ambitious activities such as sports, dancing, household chores (sweeping or putting dishes away) increase your problems?
- o No
- o Sometimes
- o Yes

9. Because of your problem, are you afraid to leave your home without having someone accompany you?
- o No
- o Sometimes
- o Yes

10. Because of your problem have you been embarrassed in front of others?
- o No
- o Sometimes
- o Yes

11. Do quick movements of your head increase your problem?
- No
- Sometimes
- Yes

12. Because of your problem, do you avoid heights?
- No
- Sometimes
- Yes

13. Does turning over in bed increase your problem?
- No
- Sometimes
- Yes

14. Because of your problem, is it difficult for you to do strenuous homework or yard work?
- No
- Sometimes
- Yes

15. Because of your problem, are you afraid people may think you are intoxicated?
- No
- Sometimes
- Yes

16. Because of your problem, is it difficult for you to go for a walk by yourself?
- No
- Sometimes
- Yes

17. Does walking down a sidewalk increase your problem?
- No
- Sometimes
- Yes

18. Because of your problem, is it difficult for you to concentrate?
- No
- Sometimes
- Yes

19. Because of your problem, is it difficult for you to walk around your house in the dark?
- No
- Sometimes
- Yes

20. Because of your problem, are you afraid to stay home alone?
- No
- Sometimes
- Yes

21. Because of your problem, do you feel handicapped?
- No
- Sometimes
- Yes

22. Has the problem placed stress on your relationships with members of your family or friends?
- No
- Sometimes
- Yes

23. Because of your problem, are you depressed?
- No
- Sometimes
- Yes

24. Does your problem interfere with your job or household responsibilities?
- No
- Sometimes
- Yes

25. Does bending over increase your problem?
- No
- Sometimes
- Yes