St. Luke's Rehabilitation Institute

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

| Item | | Response | | |
|---|---|---|---|---|
| P1 | Does looking up increase problem? | ☐ Yes | ☐ No | ☐ Sometimes |
| E2 | Because of your problem, do you feel frustrated? | ☐ Yes | ☐ No | ☐ Sometimes |
| F3 | Because of your problem, do you restrict your travel for business or recreation? | ☐ Yes | ☐ No | ☐ Sometimes |
| P4 | Does walking down the aisle of a supermarket increase your problem? | ☐ Yes | ☐ No | ☐ Sometimes |
| F5 | Because of your problem, do you have difficulty getting into or out of bed? | ☐ Yes | ☐ No | ☐ Sometimes |
| F6 | Does your problem significantly restrict your participation in social activities such as going out to dinner, going to movies, dancing or to parties? | ☐ Yes | ☐ No | ☐ Sometimes |
| F7 | Because of your problem, do you have difficulty reading | ☐ Yes | ☐ No | ☐ Sometimes |
| P8 | Does performing ambitious activities like sports, dancing, household chores such as sweeping or putting dishes away increase your problem? | ☐ Yes | ☐ No | ☐ Sometimes |
| E9 | Because of your problem, are you afraid to leave your home without having someone to accompany you? | ☐ Yes | ☐ No | ☐ Sometimes |
| E10 | Because of your problem, have you been embarrassed in front if others? | ☐ Yes | ☐ No | ☐ Sometimes |
| P11 | Do quick movements of your head increase your problem? | ☐ Yes | ☐ No | ☐ Sometimes |
| F12 | Because of your problem, do you avoid heights? | ☐ Yes | ☐ No | ☐ Sometimes |
| P13 | Does turning over in bed increase your problem? | ☐ Yes | ☐ No | ☐ Sometimes |
| F14 | Because of your problem, is it difficult for you to do strenuous housework or yard work? | ☐ Yes | ☐ No | ☐ Sometimes |
| E15 | Because of your problem, are you afraid that people may think you are intoxicated? | ☐ Yes | ☐ No | ☐ Sometimes |
| F16 | Because of your problem, is it difficult for you to go for a walk by yourself? | ☐ Yes | ☐ No | ☐ Sometimes |
| P17 | Does walking down a sloped sidewalk or ramp increase your problem? | ☐ Yes | ☐ No | ☐ Sometimes |
| E18 | Because of your problem, is it difficult for you to concentrate? | ☐ Yes | ☐ No | ☐ Sometimes |
| F19 | Because of your problem, is it difficult for you to walk around your house in the dark? | ☐ Yes | ☐ No | ☐ Sometimes |

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| | | | | |
|---|---|---|---|---|
| E20 | Because of your problem, are you afraid to stay home alone? | ☐ Yes | ☐ No | ☐ Sometimes |
| E21 | Because of your problem, do you feel handicapped? | ☐ Yes | ☐ No | ☐ Sometimes |
| E22 | Has your problem placed stress on your relationships with members of your family or friends? | ☐ Yes | ☐ No | ☐ Sometimes |
| E23 | Because of your problem, are you depressed? | ☐ Yes | ☐ No | ☐ Sometimes |
| F24 | Does your problem interfere with your job or household responsibilities? | ☐ Yes | ☐ No | ☐ Sometimes |
| P25 | Does bending over increase your problem? | ☐ Yes | ☐ No | ☐ Sometimes |

_____ _____

Patient's Signature Therapist's Signature

Score:_____/100

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