Dizziness Handicap Inventory

SCORE

Thank you for completing this patient-reported outcome questionnaire. Your responses help your provider determine the best treatment options and track your recovery progress over time. Please answer each of the questions included on this form.

Name: _____ **Date of Birth:** _____ (mm/dd/yyyy)

Pain Score: How would you rate your pain over the past 24 hours? Circle the number that best represents your pain.

No Pain	0	1	2	3	4	5	6	7	8	9	10	**Worst Pain Imaginable**

Instructions: The purpose of this scale is to identify difficulties that you may be experiencing because of your dizziness. Please check "Yes", or "Sometimes" or "No" to each question. Answer each question only as it pertains to your dizziness problem.

	Yes	Sometimes	No
P1. Does looking up increase your problem?	④	②	⓪
E2. Because of your problem, do you feel frustrated?	④	②	⓪
F3. Because of your problem, do you restrict your travel for business or pleasure?	④	②	⓪
P4. Does walking down the aisle of a supermarket increase your problem?	④	②	⓪
F5. Because of your problem, do you have difficulty getting into or out of bed?	④	②	⓪
F6. Does your problem significantly restrict your participation in social activities, such as going out to dinner, going to movies, dancing or to parties?	④	②	⓪
F7. Because of your problem, do you have difficulty reading?	④	②	⓪
F8. Does performing more ambitious activities like sports, dancing, and household chores, such as sweeping or putting dishes away; increase your problem?	④	②	⓪
E9. Because of your problem, are you afraid to leave your home without having someone accompany you?	④	②	⓪
E10. Because of your problem, have you been embarrassed in front of others?	④	②	⓪
P11. Do quick movements of your head increase your problem?	④	②	⓪
F12. Because of your problem, do you avoid heights?	④	②	⓪
P13. Does turning over in bed increase your problem?	④	②	⓪
F14. Because of your problem, is it difficult for you to do strenuous housework or yard work?	④	②	⓪
E15. Because of your problem, are you afraid people may think that you are intoxicated?	④	②	⓪
F16. Because of your problem, is it difficult for you to go for a walk by yourself?	④	②	⓪
P17. Does walking down a sidewalk increase your problem?	④	②	⓪
E18. Because of your problem, is it difficult for you to concentrate?	④	②	⓪
F19. Because of your problem, is it difficult for you to walk around your house in the dark?	④	②	⓪
E20. Because of your problem, are you afraid to stay home alone?	④	②	⓪
E21. Because of your problem, do you feel handicapped?	④	②	⓪
E22. Has your problem placed stress on your relationship with members of your family or friends?	④	②	⓪
E23. Because of your problem, are you depressed?	④	②	⓪
F24. Does your problem interfere with your job or household responsibilities?	④	②	⓪
P25. Does bending over increase your problem?	④	②	⓪

Scoring

1. For each item, the following scores can be assigned: Yes = 4 Sometimes = 2 No = 0
2. The total points from all items are summed. The maximum score is 100 (maximum perceived disability).
3. Questions are designed to incorporate Functional (F), Physical (P), and Emotional (E) impacts on disability.