



**Outpatient Rehabilitation
Dizziness Handicap Inventory**

Physical Therapy Occupational Therapy

PATIENT ID LABEL

INSTRUCTIONS: The purpose of this questionnaire is to identify difficulties that you may be experiencing because of your dizziness. Please answer every question. Please do not skip any questions.

		Yes	Sometimes	No
P	1. Does looking up increase your problem?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
E	2. Because of your problem, do you feel frustrated?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
F	3. Because of your problem, do you restrict your travel for business or recreation?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
P	4. Does walking down the aisle of a supermarket increase your problem?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
F	5. Because of your problem, do you have difficulty getting into or out of bed?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
F	6. Does your problem significantly restrict your participation in social activities such as going out to dinner, going to movies, dancing, or to parties?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
F	7. Because of your problem, do you have difficulty reading?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
P	8. Does performing more ambitious activities like sports, dancing, household chores such as sweeping or putting dishes away increase your problem?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
E	9. Because of your problem, are you afraid to leave home without having someone with you?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
E	10. Because of your problem, have you been embarrassed in front of others?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
P	11. Do quick movements of your head increase your problem?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
F	12. Because of your problem, do you avoid heights?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
P	13. Does turning over in bed increase your problem?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
F	14. Because of your problem, is it difficult for you to do strenuous housework or yard work?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
E	15. Because of your problem, are you afraid people may think you are intoxicated?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
F	16. Because of your problem, is it difficult for you to go for a walk by yourself?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
P	17. Does walking down a sidewalk increase your problem?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
E	18. Because of your problem, is it difficult for you to concentrate?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
F	19. Because of your problem, is it difficult for you to go for a walk around your house in the dark?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
E	20. Because of your problem, are you afraid to stay home alone?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
E	21. Because of your problem, do you feel handicapped?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
E	22. Has your problem placed stress on your relationship with members of your family or friends?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
E	23. Because of your problem, are you depressed?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
F	24. Does your problem interfere with your job or household responsibilities?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
P	25. Does bending over increase your problem?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
TOTAL:		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
		(x 4)	(x 2)	(x 0)

"Dizziness, Handicap Index" Jacobson, Newman Arch Otolaryngol Head Neck Surg 116:424, 1990.

FOR THERAPIST USE ONLY: P ___ / 28 E ___ / 26 F ___ / 36 Total ___ / 100

Scoring: 0 - 30 Mild Disability 31 - 60 Moderate Disability 61 - 100 Severe Disability

Patient Signature: _____ Date: _____ Time: _____

Therapist Signature / License #: _____ Date: _____ Time: _____

