

PATIENT NAME: _____

MR #: _____

DATE: _____

DIZZINESS HANDICAP INVENTORY

	Yes	Sometimes	No	
1. Does looking up increase your problem?				P
2. Because of your problem, do you feel frustrated?				E
3. Because of your problem, do you restrict your travel for business or recreation?				F
4. Does walking down the aisle of a supermarket increase your problem?				P
5. Because of your problem, do you have difficulty getting into or out of bed?				F
6. Does your problem significantly restrict your participation in social events such as going out to dinner, going to the movies, dancing or to parties?				F
7. Because of your problem, do you have difficulty reading?				F
8. Does performing more ambitious activities like sports, dancing, household chores such as sweeping or putting dishes away increase your problem?				P
9. Because of your problem, are you afraid to leave your home without having someone accompany you?				E
10. Because of your problem, have you been embarrassed in front of others?				E
11. Do quick movements of your head increase your problem?				P
12. Because of your problem, do you avoid heights?				F
13. Does turning over in bed increase your problem?				P
14. Because of your problem, is it difficult for you to do strenuous housework or yard work?				F
15. Because of your problem, are you afraid people may think you are intoxicated?				E

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	Yes	Sometimes	No	
16. Because of your problem, is it difficult for you to go for a walk by yourself?				F
17. Does walking down a sidewalk increase your problem?				P
18. Because of your problem, is it difficult for you to concentrate?				E
19. Because of your problem, is it difficult for you to walk around the house in the dark?				F
20. Because of your problem, are you afraid to stay home alone?				E
21. Because of your problem, do you feel handicapped?				E
22. Has your problem placed stress on your relationships with members of your family or friends?				E
23. Because of your problem, are you depressed?				E
24. Does your problem interfere with your job or household responsibilities?				F
25. Does bending over increase your problem?				P

	Total
P: Physical	
E: Emotional	
F: Functional	
TOTAL	
IMPAIRMENT	

16-34 Points (mild handicap)
36-52 Points (moderate handicap)
54+ Points (severe handicap)

Therapist Name _____

Therapist Signature _____