Smith Physical Therapy + Running Academy

DIZZINESS HANDICAP INVENTORY

Name: _____ **Date:** ____ / ____ / _____

Instructions: The purpose of this scale is to identify difficulties that you may be experiencing because of your dizziness. Please check "always," "sometimes," or "no" to each question. **Answer each question only as it pertains to your dizziness/unsteadiness problem**.

P1	Does looking up increase your problem?	☐ Always ☐ Sometimes ☐ Never
E2	Because of your problem, do you feel frustrated?	☐ Always ☐ Sometimes ☐ Never
F3	Because of your problem, do you restrict your travel for business or pleasure?	☐ Always ☐ Sometimes ☐ Never
P4	Does walking down the aisle of a supermarket increase your problem?	☐ Always ☐ Sometimes ☐ Never
F5	Because of your problem, do you have difficulty getting into or out of bed?	☐ Always ☐ Sometimes ☐ Never
F6	Does your problem significantly restrict your participation in social activities, such as going out to dinner, movies, or parties?	☐ Always ☐ Sometimes ☐ Never
F7	Because of your problem, do you have difficulty reading?	☐ Always ☐ Sometimes ☐ Never
F8	Does performing more ambitious activities like sports, dancing, and household chores (such as sweeping or putting dishes away) increase your problem?	☐ Always ☐ Sometimes ☐ Never
E9	Because of your problem, are you afraid to leave your home without having someone accompany you?	☐ Always ☐ Sometimes ☐ Never
E10	Because of your problem, have you been embarrassed in front of others?	☐ Always ☐ Sometimes ☐ Never
P11	Do quick movements of your head increase your problem?	☐ Always ☐ Sometimes ☐ Never
F12	Because of your problem, do you avoid heights?	☐ Always ☐ Sometimes ☐ Never
P13	Does turning over in bed increase your problem?	☐ Always ☐ Sometimes ☐ Never
F14	Because of your problem, is it difficult for you to do strenuous housework or yard work?	☐ Always ☐ Sometimes ☐ Never
E15	Because of your problem, are you afraid people may think that you are intoxicated?	☐ Always ☐ Sometimes ☐ Never
F16	Because of your problem, is it difficult for you to go for a walk by yourself?	☐ Always ☐ Sometimes ☐ Never
P17	Does walking down a sidewalk increase your problem?	☐ Always ☐ Sometimes ☐ Never
E18	Because of your problem, is it difficult for you to concentrate?	☐ Always ☐ Sometimes ☐ Never

F19	Because of your problem, is it difficult for you to walk around your house in the dark?	☐ Always ☐ Sometimes ☐ Never
E20	Because of your problem, are you afraid to stay home alone?	☐ Always ☐ Sometimes ☐ Never
E21	Because of your problem, do you feel handicapped?	☐ Always ☐ Sometimes ☐ Never
E22	Has your problem placed stress on your relationship with members of your family or friends?	☐ Always ☐ Sometimes ☐ Never
E23	Because of your problem, are you depressed?	☐ Always ☐ Sometimes ☐ Never
F24	Does your problem interfere with your job or household responsibilities?	☐ Always ☐ Sometimes ☐ Never
P25	Does bending over increase your problem?	☐ Always ☐ Sometimes ☐ Never