The Dizziness Handicap Inventory (DHI)

PATIENT NAME:	P13. Does turning over in bed increase your problem? ☐ Yes ☐ Sometimes ☐ No
P1. Does looking up increase your problem? ☐ Yes ☐ Sometimes ☐ No	F14. Because of your problem, is it difficult for you to do strenuous homework or yard work? ☐ Yes ☐ Sometimes ☐ No
E2. Because of your problem, do you feel frustrated? ☐ Yes ☐ Sometimes ☐ No	E15. Because of your problem, are you afraid people may think you are intoxicated? ☐ Yes ☐ Sometimes ☐ No
F3. Because of your problem, do you restrict your travel for business or recreation? ☐ Yes ☐ Sometimes ☐ No	F16. Because of your problem, is it difficult for you to go for a walk by yourself? ☐ Yes ☐ Sometimes ☐ No
P4. Does walking down the aisle of a supermarket increase your problems? ☐ Yes ☐ Sometimes ☐ No	P17. Does walking down a sidewalk increase your problem? ☐ Yes ☐ Sometimes ☐ No
F5. Because of your problem, do you have difficulty getting into or out of bed? ☐ Yes ☐ Sometimes ☐ No	E18. Because of your problem, is it difficult for you to concentrate? ☐ Yes ☐ Sometimes ☐ No
F6. Does your problem significantly restrict your participation in social activities, such as going out to dinner, going to the movies, dancing, or going to parties? ☐ Yes ☐ Sometimes ☐ No	F19. Because of your problem, is it difficult for you to walk around your house in the dark? ☐ Yes ☐ Sometimes ☐ No
F7. Because of your problem, do you have difficulty reading? ☐ Yes ☐ Sometimes ☐ No	E20. Because of your problem, are you afraid to stay home alone? ☐ Yes ☐ Sometimes ☐ No
P8. Does performing more ambitious activities such as sports, dancing, household chores (sweeping or putting dishes away) increase your problems? ☐ Yes ☐ Sometimes ☐ No	E21. Because of your problem, do you feel handicapped? ☐ Yes ☐ Sometimes ☐ No
E9. Because of your problem, are you afraid to leave your home without having someone accompany you? ☐ Yes ☐ Sometimes ☐ No	E22. Has the problem placed stress on your relationships with members of your family or friends? ☐ Yes ☐ Sometimes ☐ No
E10. Because of our problem have you been embarrassed in front of others? ☐ Yes ☐ Sometimes ☐ No	E23. Because of your problem, are you depressed? ☐ Yes ☐ Sometimes ☐ No
P11. Do quick movements of your head increase your problem? ☐ Yes ☐ Sometimes ☐ No	F24. Does your problem interfere with your job or household responsibilities? ☐ Yes ☐ Sometimes ☐ No
F12. Because of your problem, do you avoid heights? ☐ Yes ☐ Sometimes ☐ No	F25 Does bending over increase your problem? ☐ Yes ☐ Sometimes ☐ No

Therapist use only: TOTAL SCORE _____ P _____ E _____ F _____

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