DIZZINESS HANDICAP INVENTORY Name: _____Date: _____

The purpose of this scale is to identify difficulties that you may be experiencing because of your dizziness or unsteadiness. Please indicate answer by circling "yes"/"no"/"sometimes" for each question. Answer each question as it pertains to your dizziness or unsteadiness problem only.

Physical Items

Does looking up increase your problem? **Yes No Sometimes**
Does walking down the aisle of a supermarket increase your problem? **Yes No Sometimes**
Performing more ambitious activities like sports/household chores increases my problem. **Yes No Sometimes**
Do quick movements of your head increase your problem? **Yes No Sometimes**
Does turning over in bed increase your problem? **Yes No Sometimes**
Does walking down a sidewalk increase your problem? **Yes No Sometimes**
Does bending over increase your problem? **Yes No Sometimes**

Emotional Items

BECAUSE OF YOUR PROBLEM...

Do you feel frustrated? **Yes No Sometimes**
Are you afraid to leave your home without having someone accompany you? **Yes No Sometimes**
Have you been embarassed in front of others? **Yes No Sometimes**
Are you afraid people might think you're intoxicated? **Yes No Sometimes**
Is it difficult for you to concentrate? **Yes No Sometimes**
Are you afraid to stay home alone? **Yes No Sometimes**
Do you feel handicapped? **Yes No Sometimes**
Has stress been placed on your relationships with members of your family or friends? **Yes No Sometimes**
Are you depressed? **Yes No Sometimes**

Functional Items

BECAUSE OF YOUR PROBLEM...

Is it difficult to walk around your house in the dark? **Yes No Sometimes**
Is it difficult to do your job or household responsibilities? **Yes No Sometimes**
Do you restrict your travel for business or recreation? **Yes No Sometimes**
Do you have difficulty getting into or out of bed? **Yes No Sometimes**
Do you significantly restrict your participation in social activities? **Yes No Sometimes**
Do you have difficulty reading? **Yes No Sometimes**
Is it difficult for you to do strenuous house or yard work? **Yes No Sometimes**
Is it difficult for you to go for a walk by yourself? **Yes No Sometimes**
Do you avoid heights? **Yes No Sometimes**

Please CIRCLE the statement that BEST describes you.

My symptoms are insignificant (0)
My symptoms are bothersome (1)
I perform my usual work duties but symptoms interfere with outside activities (2)
My symptoms disrupt performance of both ususal work duties and outside activities (3)
I am currently on medical leave or had to change jobs because of my symptoms (4)
I have been unable to work for over one year, or have established permanent disability with compensation payments (5)

!! STOP HERE !!

YES SOMETIMES NO

P (7) _____ x4=_____ + _____ x2=_____+ _____x0=_____ Physical _____/28

E (9) _____ x4=_____ + _____x2=_____ +_____x0=_____ Emotional _____/36

F (9) _____ x4=_____ + _____ x2=_____ +_____x0=_____ Functional _____/36 TOTAL _____/100