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 answer each question as it pertains to your dizziness or unsteadiness problem only.

P1. Does looking up increase your problem?	Yes	No	Sometimes
P2. Does walking down the aisles of a supermarket without a cart increase your problem?	Yes	No	Sometimes
P3. Does performing more ambitious activities like sports, dancing or household chores increase your problem?	Yes	No	Sometimes
P4. Do quick head movements increase your problem?	Yes	No	Sometimes
P5. Does turning over in bed increase your problem?	Yes	No	Sometimes
P6. Does bending over increase your problem?	Yes	No	Sometimes
P7. Does walking down a sidewalk increase your problem?	Yes	No	Sometimes
F8. Because of your problem, do you have difficulty getting into or out of bed?	Yes	No	Sometimes
F9. Does your problem significantly restrict your participation in social activities (i.e. movies, dancing, parties)?	Yes	No	Sometimes
F10. Because of your problem, do you have difficulty reading?	Yes	No	Sometimes
F11. Does your problem interfere with your job or household responsibilities?	Yes	No	Sometimes
F12. Because of your problem, is it difficult for you to do strenuous housework or yardwork?	Yes	No	Sometimes
F13. Because of your problem, is it difficult for you to walk around your house in the dark?	Yes	No	Sometimes
F14. Because of your problem, do you restrict your travel for business or recreation?	Yes	No	Sometimes
F15. Because of your problem, is it difficult for you to walk by yourself?	Yes	No	Sometimes
F16. Because of your problem, do you avoid heights?	Yes	No	Sometimes
E17. Because of your problem, are you afraid people might think you're intoxicated?	Yes	No	Sometimes
E18. Because of your problem, do you have someone accompany you when you leave home?	Yes	No	Sometimes
E19. Because of your problem, is it difficult for you to concentrate?	Yes	No	Sometimes
E20. Because of your problem, do you feel frustrated?	Yes	No	Sometimes
E21. Because of your problem, are you afraid to stay home alone?	Yes	No	Sometimes
E22. Because of your problem, are you embarrassed in front of others?	Yes	No	Sometimes
E23. Because of your problem, do you feel handicapped?	Yes	No	Sometimes
E24. Has your problem placed stress on your relationships with family members or friends?	Yes	No	Sometimes
E25. Because of your problem, are you depressed?	Yes	No	Sometimes

	___x4	___x0	___x2
TOTAL	____	____	____

P_____ **E**_____ **F**_____

BARRINGTON REHABILITATION