



## DIZZINESS HANDICAP INVENTORY (DHI)

Name: \_\_\_\_\_ Date: \_\_\_\_\_

**Instructions:** Please circle the number corresponding to “yes,” “no,” or “sometimes” in response to the questions.

STATEMENTS	Yes	No	Sometimes
1. Does looking up increase your problem?	4	0	2
2. Because of your problem, do you feel frustrated?	4	0	2
3. Because of your problem, do you restrict your travel for business or recreation?	4	0	2
4. Does walking down the aisle of a supermarket increase your problem?	4	0	2
5. Because of your problem, do you have difficulty getting into or out of bed?	4	0	2
6. Does your problem significantly restrict your participation in social activities such as going out to dinner, going to the movies, dancing, or to parties?	4	0	2
7. Because of your problem, do you having difficulty reading?	4	0	2
8. Does performing more ambitious activities like sports, dancing, household chores such as sweeping or putting dishes away increase your problem?	4	0	2
9. Because of your problem, are you afraid to leave your home without having someone accompany you?	4	0	2
10. Because of your problem, have you been embarrassed in front of others?	4	0	2
11. Do quick movements of your head increase your problem?	4	0	2
12. Because of your problem, do you avoid heights?	4	0	2
13. Does turning over in bed increase your problem?	4	0	2
14. Because of your problem, is it difficult for you to do strenuous housework or yard work?	4	0	2
15. Because of your problem, are you afraid people may think you are intoxicated?	4	0	2
16. Because of your problem, is it difficult for you to walk by yourself?	4	0	2
17. Does walking down a sidewalk increase your problem?	4	0	2
18. Because of your problem, is it difficult for you to concentrate?	4	0	2
19. Because of your problem, is it difficult for you to walk around your house in the dark?	4	0	2
20. Because of your problem, are you afraid to stay home alone?	4	0	2
21. Because of your problem, do you feel handicapped?	4	0	2
22. Has your problem placed stress on your relationships with members of your family or friends?	4	0	2
23. Because of your problem, are you depressed?	4	0	2
24. Does your problem interfere with your job or household responsibilities?	4	0	2
25. Does bending over cause your problem?	4	0	2

**For Office Use Only: Total Score:** \_\_\_\_\_