Centers for Rehab Services
A Partner of UPMC

Name_____
DOB_____
Date_____

Dizziness Handicap Inventory (DHI)

The purpose of this scale is to identify difficulties that you may be experiencing because of your dizziness. Please answer "Yes", "No" or "Sometimes" to each question. Answer each question as it pertains to your dizziness problem only.

		YES	SOMETIMES	NO
1.	Does looking up increase your problem?	☐	☐	☐
2.	Because of your problem, do you feel frustrated?	☐	☐	☐
3.	Because of your problem, do you restrict your travel for business or recreation?	☐	☐	☐
4.	Does walking down the aisle of a supermarket increase your problem?	☐	☐	☐
5.	Because of your problem, do you have difficulty getting out of bed?	☐	☐	☐
6.	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?	☐	☐	☐
7.	Because of your problem, do you have difficulty reading?	☐	☐	☐
8.	Does performing more ambitious activities like sports, dancing, household chores, such as sweeping or putting dishes away, increase your problem?	☐	☐	☐
9.	Because of your problem, are you afraid to leave your home without having someone to accompany you?	☐	☐	☐
10.	Because of your problem, have you been embarrassed in front of others?	☐	☐	☐
11.	Do quick movements of your head increase your problems?	☐	☐	☐
12.	Because of your problem, do you avoid heights?	☐	☐	☐

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	YES	SOMETIMES	NO
13. Does turning over in bed increase your problem?	☐	☐	☐
14. Because of your problem, is it difficult for you to do strenuous housework or yard work?	☐	☐	☐
15. Because of your problem, are you afraid people may think that you are intoxicated?	☐	☐	☐
16. Because of your problem, is it difficult for you to walk by yourself?	☐	☐	☐
17. Does walking down a sidewalk increase your problem?	☐	☐	☐
18. Because of your problem, is it difficult for you to concentrate?	☐	☐	☐
19. Because of your problem, is it difficult for you to walk around your house in the dark?	☐	☐	☐
20. Because of your problem, are you afraid to stay at home alone?	☐	☐	☐
21. Because of your problem, do you feel handicapped?	☐	☐	☐
22. Has your problem placed stress on your relationship with members of your family or friends?	☐	☐	☐
23. Because of your problem, are you depressed?	☐	☐	☐
24. Does your problem interfere with your job or house responsibilities?	☐	☐	☐
25. Does bending over increase your problem?	☐	☐	☐