

PATIENT NAME: _____

Dizziness Handicap Inventory

DATE: _____

Instructions: The purpose of this scale is to identify difficulties that you may be experiencing because of your dizziness. Please check “always”, or “no” or “sometimes” to each question. Answer each question only as it pertains to your dizziness problem.

	Questions	Always	Sometimes	No
P1	Does looking up increase your problem?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
E2	Because of your problem, do you feel frustrated?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
F3	Because of your problem, do you restrict your travel for business or pleasure?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
P4	Does walking down the aisle of a supermarket increase your problem?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
F5	Because of your problem, do you have difficulty getting into or out of bed?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
F6	Does your problem significantly restrict your participation in social activities, such as going out to dinner, going to movies, dancing or to parties?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
F7	Because of your problem, do you have difficulty reading?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
F8	Does performing more ambitious activities like sports, dancing, and household chores, such as sweeping or putting dishes away; increase your problem?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
E9	Because of your problem, are you afraid to leave your home without having someone accompany you?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
E10	Because of your problem, have you been embarrassed in front of others?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
P11	Do quick movements of your head increase your problem?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
F12	Because of your problem, do you avoid heights?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
P13	Does turning over in bed increase your problem?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
F14	Because of your problem, is it difficult for you to do strenuous housework or yard work?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
E15	Because of your problem, are you afraid people may think that you are intoxicated?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
F16	Because of your problem, is it difficult for you to go for a walk by yourself?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
P17	Does walking down a sidewalk increase your problem?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
E18	Because of your problem, is it difficult for you to concentrate?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
F19	Because of your problem, is it difficult for you to walk around your house in the dark?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
E20	Because of your problem, are you afraid to stay home alone?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
E21	Because of your problem, do you feel handicapped?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
E22	Has your problem placed stress on your relationship with members of your family or friends?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
E23	Because of your problem, are you depressed?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
F24	Does your problem interfere with your job or household responsibilities?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
P25	Does bending over increase your problem?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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Scoring for Dizziness Handicap Inventory

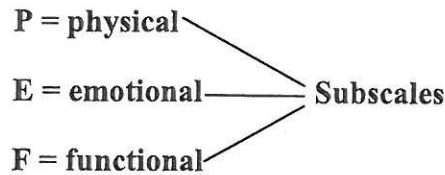
DATE: _____

Eval	Total Functional	Total Emotional	Total Physical	TOTAL SCORE
Reassess #1				
Reassess #2				
Reassess #3				
Reassess #4				

Always = 4

Sometimes = 2

No = 0



Notes:

1. Subjective measure of the patient's perception of handicap due to the dizziness
2. Top score is 100 (maximum perceived disability)
3. Bottom score is 0 (no perceived disability)
4. The following 5 items can be useful in predicting BPPV
 - Does looking up increase your problem?
 - Because of your problem, do you have difficulty getting into or out of bed?
 - Do quick movements of your head increase your problem?
 - Does bending over increase your problem?
5. Can use subscale scores to track change as well

DHI Scoring Instructions

The patient is asked to answer each question as it pertains to dizziness or unsteadiness problems, specifically considering their condition during the last month. Questions are designed to incorporate functional (F), physical (P), and emotional (E) impacts on disability.

To each item, the following scores can be assigned:

No=0 Sometimes=2 Yes=4

Scores:

Scores greater than 10 points should be referred to balance specialists for further evaluation.

16-34 Points (mild handicap)

36-52 Points (moderate handicap)

54+ Points (severe handicap)