# DIZZINESS HANDICAP INVENTORY (DHI)

Name _____ Date _____

INSTRUCTIONS: The purpose of this scale is to identify difficulties that you may be experiencing because of your dizziness or unsteadiness. Please answer "Yes", "No", or "Sometimes" to each question.

Answer each question as it applies to your DIZZINESS or unsteadiness only.

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