

DIZZINESS HANDICAP INVENTORY (DHI)

Name:		Age:	
Date:		Date of Birth:	

Instructions: Read each question and circle "Yes", "Sometimes" or "No".

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

Continued...

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

Developed by Dr. G.P. Jacobson and Dr. C.W. Newman, 1990



Scoring: Yes = 4 points; Sometimes = 2 points; No = 0 points

Functional Subscale (F):	/36
Emotional Subscale (E):	/36
Physical Subscale (P):	/28
Total Score:	/100

Key	
0 – 30	= Mild Deficit
31 – 60	= Moderate Deficit
61 – 100	= Severe Deficit