Dizziness Handicap Inventory

physical therapy occupational therapy ...with a smile:)

P1. Does looking up increase your problem?	☐ Yes ☐ Sometimes ☐ No
E2. Because of your problem, do you feel frustrated?	☐ Yes ☐ Sometimes ☐ No
F3. Because of your problem, do you restrict your travel for business or recreation?	☐ Yes ☐ Sometimes ☐ No
P4. Does walking down the aisle of a supermarket increase your problems?	☐ Yes ☐ Sometimes ☐ No
F5. Because of your problem, do you have difficulty getting into or out of bed?	☐ Yes ☐ Sometimes ☐ No
F6. 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?	☐ Yes ☐ Sometimes ☐ No
F7. Because of your problem, do you have difficulty reading?	☐ Yes ☐ Sometimes ☐ No
PB. Does performing more ambitious activities such as sports, dancing, household chores (sweeping or putting dishes away) increase your problems?	☐ Yes ☐ Sometimes ☐ No
E9. Because of your problem, are you afraid to leave your home without having someone accompany you?	☐ Yes ☐ Sometimes ☐ No
E10. Because of your problem have you been embarrassed in front of others?	☐ Yes ☐ Sometimes ☐ No
P11. Do quick movements of your head increase your problem?	☐ Yes ☐ Sometimes ☐ No
F12 . Because of your problem, do you avoid heights?	☐ Yes ☐ Sometimes ☐ No
P13 . Does turning over in bed increase your problem?	☐ Yes ☐ Sometimes ☐ No
F14. Because of your problem, is it difficult for you to do strenuous homework or yard work?	☐ Yes ☐ Sometimes ☐ No
E15. Because of your problem, are you afraid people may think you are intoxicated?	☐ Yes ☐ Sometimes ☐ No
F16. Because of your problem, is it difficult for you to go for a walk by yourself?	☐ Yes ☐ Sometimes ☐ No
P17. Does walking down a sidewalk increase your problem?	☐ Yes ☐ Sometimes ☐ No
E18. Because of your problem, is it difficult for you to concentrate?	☐ Yes ☐ Sometimes ☐ No
F19. Because of your problem, is it difficult for you to walk around your house in the dark?	☐ Yes ☐ Sometimes ☐ No
E20. Because of your problem, are you afraid to stay home alone?	☐ Yes ☐ Sometimes ☐ No
E21. Because of your problem, do you feel handicapped?	☐ Yes ☐ Sometimes ☐ No
E22. Has the problem placed stress on your relationships with members of your family or friends?	☐ Yes ☐ Sometimes ☐ No
E23. Because of your problem, are you depressed?	☐ Yes ☐ Sometimes ☐ No
F24. Does your problem interfere with your job or household responsibilities?	☐ Yes ☐ Sometimes ☐ No
P25. Does bending over increase your problem?	☐ Yes ☐ Sometimes ☐ No