DIZZINESS HANDICAP INVENTORY - Initial Visit

Name:_____ **Date:**_____

SECTION I

1. Please rate your pain level with activity: NO PAIN=0 1 2 3 4 5 6 7 8 9 10=VERY SEVERE PAIN

SECTION II – Part I

Instructions: The purpose of this scale is to identify difficulties that you may be experiencing because of your dizziness or unsteadiness. Please indicate answer by circling "yes" or "no" or "sometimes" for each question. Answer each question as it pertains to your dizziness or unsteadiness problem only.

P1. Does looking up increase your problem?	Yes[1]	No[2]	Sometimes[3]
E2. Because of your problem, do you feel frustrated?	Yes[1]	No[2]	Sometimes[3]
F3. Because of your problem, do you restrict your travel for business and recreation?	Yes[1]	No[2]	Sometimes[3]
P4. Does walking down the aisle of a supermarket increase your problem?	Yes[1]	No[2]	Sometimes[3]
F5. Because of your problem, do you have difficulty getting or out of bed?	Yes[1]	No[2]	Sometimes[3]
F6. Does your problem significantly restrict your participation in social activities such as going out to dinner, going to the movies, dancing or parties?	Yes[1]	No[2]	Sometimes[3]
F7. Because of your problem, do you have difficulty reading?	Yes[1]	No[2]	Sometimes[3]
P8. Does performing more ambitious activities like sports, dancing, household chores such as sweeping or putting dishes away increase your problem?	Yes[1]	No[2]	Sometimes[3]
E9. Because of your problem, are you afraid to leave your home without having someone accompany you?	Yes[1]	No[2]	Sometimes[3]
E10. Because of your problem, have you been embarrassed in front of others?	Yes[1]	No[2]	Sometimes[3]
P11. Do quick movements of your head increase your problem?	Yes[1]	No[2]	Sometimes[3]
F12. Because of your problem, do you avoid heights?	Yes[1]	No[2]	Sometimes[3]
P13. Does turning over in bed increase your problem?	Yes[1]	No[2]	Sometimes[3]
F14. Because of your problem, is it difficult for you to do strenuous housework or yard work?	Yes[1]	No[2]	Sometimes[3]
E15. Because of your problem, are you afraid people may think you are intoxicated?	Yes[1]	No[2]	Sometimes[3]
F16. Because of your problem, is it difficult for you to go for a walk by yourself?	Yes[1]	No[2]	Sometimes[3]
P17. Does walking down a sidewalk increase your problem?	Yes[1]	No[2]	Sometimes[3]
E18. Because of your problem, is it difficult for you to concentrate?	Yes[1]	No[2]	Sometimes[3]
F19. Because of your problem, is it difficult for you to walk around the house in the dark?	Yes[1]	No[2]	Sometimes[3]
E20. Because of your problem, are you afraid to stay home alone?	Yes[1]	No[2]	Sometimes[3]
E21. Because of your problem, do you feel handicapped?	Yes[1]	No[2]	Sometimes[3]
E22. Has your problem placed stress on your relationships with members of your family and friends?	Yes[1]	No[2]	Sometimes[3]
E23. Because of your problem are you depressed?	Yes[1]	No[2]	Sometimes[3]

F24. Does your problem interfere with your job or household responsibilities? Yes[1] No[2] Sometimes[3]

P25. Does bending over increase your problem? Yes[1] No[2] Sometimes[3]

SECTION II – Part II

Instructions: Put a check in the box that best describes you:

- ❑ Negligible symptoms (0)
- ❑ Bothersome symptoms (1)
- ❑ Performs usual work duties but symptoms interfere with outside activities (2)
- ❑ Symptoms disrupt performance of both usual work duties and outside activities (3)
- ❑ Currently on medical leave or had to change jobs because of symptoms (4)
- ❑ Unable to work for over one year or established permanent disability with compensation payments (5)

Therapist Use Only			
Comorbidities:	☐Cancer ☐Diabetes ☐Heart Condition ☐High Blood Pressure ☐Multiple Treatment Areas	☐Neurological Disorders (e.g., Parkinson's, Muscular Dystrophy, Huntington's, CVA, Alzheimer's, TBI) ☐Obesity ☐Surgery for this Problem ☐Systemic Disorders (e.g., Lupus, Rheumatoid Arthritis, Fibromyalgia)	ICD9 Code: _____