DIZZINESS HANDICAP INVENTORY (YO TH VERSION)

Patient Name _____ Date_____

INSTRUCTIONS: Please CIRCLE the correct response:

1. I have dizziness/unsteadiness: (1) 1 per month (2) >1 byt <4 per month (3) more than one per week
2. My dizziness/unsteadiness is: (1) mild (2) moderate (3) severe

Please read carefully: The purpose of the scale is to identify difficulties that you may be experiencing because of your dizziness/ unsteadiness. Please check off "YES", "SOMETIMES" or "NO" to each item. Answer each question as it pertains to your dizziness/ unsteadiness only.

YES	SOMETIMES	NO		
☐	☐	☐	P1.	Does looking up increase your problem?
☐	☐	☐	E2.	Because of your problem, do you feel frustrated?
☐	☐	☐	F3.	Because of your problem, do you restrict your play, getting together with friends, sports or attendance at school?
☐	☐	☐	P4.	Does walking in the hallways at school increase your problem?
☐	☐	☐	F5.	Because of your problem, do you have difficulty getting into or out of bed?
☐	☐	☐	F6.	Does your problem significantly restrict your participation in social activities such as going out to dinner, going to movies, dancing, the mall or parties?
☐	☐	☐	F7.	Because of your problem, do you have difficulty reading?
☐	☐	☐	P8.	Does performing more ambitious activities like sports, dancing. household chores (sweeping or putting dishes away) increase your problem?
☐	☐	☐	E9.	Because of your problem, are you afraid to leave your home without someone accompanying you?
☐	☐	☐	E10.	Because of your problem, have you been embarrassed in front of others?
☐	☐	☐	P11.	Do quick movements of your head increase your problem?
☐	☐	☐	F12.	Because or your problem, do you avoid heights?
☐	☐	☐	P 1 3.	Does turning over in bed increase your problem?
☐	☐	☐	F14.	Because of your problem, is it difficult for you to do strenuous activity such as carrying your backpack or performing light exercise?
☐	☐	☐	E15.	Because of your problem,do you feel like friends notice you are not able to walk straight without weaving?
☐	☐	☐	F16.	Because of your problem. is it difficult for you to go for a walk by yourself?
☐	☐	☐	P17.	Does walking down a sidewalk or uneven surfaces increase your problem?
☐	☐	☐	E18.	Because of your problem, is it difficult for you to concentrate?
☐	☐	☐	F19.	Because of your problem, is it difficult for you to walk in the dark?
☐	☐	☐	E20.	Because o(your problem, are you afraid to stay home alone?
☐	☐	☐	E21.	Because of your problem, do you feel unable to participate in the things your friends are doing?
☐	☐	☐	E22.	Has your problem placed stress on your relationships with members of your family or friends?
☐	☐	☐	E23.	Because of your problem, are you sad?
☐	☐	☐	F24.	Does your problem interfere with your schoolwork or household responsibilities?
☐	☐	☐	P25.	Does bending over increase your problem?

For Office Use Only: Total Score:_____

P_____ E_____ F_____