

DIZZINESS HANDICAP INVENTORY (YOUTH VERSION)

Patient Name _____

Date _____

INSTRUCTIONS: Please CIRCLE the correct response:

1. I have dizziness/unsteadiness: (1) 1 per month (2) >1 but <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 | |
|--------------------------|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | P1. Does looking up increase your problem? |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | E2. Because of your problem, do you feel frustrated? |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | F3. Because of your problem, do you restrict your play, getting together with friends, sports or attendance at school? |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | P4. Does walking in the hallways at school increase your problem? |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | F5. Because of your problem, do you have difficulty getting into or out of bed? |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 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? |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | F7. Because of your problem, do you have difficulty reading? |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | P8. Does performing more ambitious activities like sports, dancing, household chores (sweeping or putting dishes away) increase your problem? |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | E9. Because of your problem, are you afraid to leave your home without someone accompanying you? |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | E10. Because of your problem, have you been embarrassed in front of others? |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | P11. Do quick movements of your head increase your problem? |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | F12. Because of your problem, do you avoid heights? |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | P13. Does turning over in bed increase your problem? |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | F14. Because of your problem, is it difficult for you to do strenuous activity such as carrying your backpack or performing light exercise? |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | E15. Because of your problem, do you feel like friends notice you are not able to walk straight without weaving? |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | F16. Because of your problem, is it difficult for you to go for a walk by yourself? |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | P17. Does walking down a sidewalk or uneven surfaces increase your problem? |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | E18. Because of your problem, is it difficult for you to concentrate? |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | F19. Because of your problem, is it difficult for you to walk in the dark? |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | E20. Because of your problem, are you afraid to stay home alone? |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | E21. Because of your problem, do you feel unable to participate in the things your friends are doing? |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | E22. Has your problem placed stress on your relationships with members of your family or friends? |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | E23. Because of your problem, are you sad? |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | F24. Does your problem interfere with your schoolwork or household responsibilities? |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | P25. Does bending over increase your problem? |

For Office Use Only:

Total Score: _____

P _____ E _____ F _____