Edward Rehab Services
and Sports Medicine

DIZZINESS HANDICAP INDEX

NAME:_____ DATE:_____

The purpose of this scale is to identify difficulties that you may be experiencing because of your dizziness or unsteadiness. Please answer "Yes", "No", or "Sometimes" to each question by writing the corresponding letter in the blanks on the right side of the paper. *Answer each question as it pertains to your dizziness or unsteadiness only*.

YES – (Y)
NO – (N)
SOMETIMES – (S)

			Internal use P	E	F
1	Does looking up increase your problem?				
2	Because of your problem, do you feel frustrated?				
3	Because of your problem, do you restrict your travel for business or recreation?				
4	Does walking down the aisle of a supermarket increase your problem?				
5	Because of your problem, do you have difficulty getting into or out of bed?				
6	Does your problem significantly restrict social activities like going out to dinner, movies, dancing, or to parties?				
7	Because of your problem, do you have difficulty reading?				
8	Do performing ambitious activities like sports, dancing, sweeping or putting dishes away increase the problem?				
9	Because of your problem, are you afraid to leave your home without having someone accompany you?				
10	Because of your problem, have you been embarrassed in front of others?				
11	Do quick movements of your head increase your problem?				
12	Because of your problem, do you avoid heights?				
13	Does turning over in bed increase your problem?				
14	Because of your problem, is it difficult for you to do strenuous housework or yard work?				
15	Because of your problem, are you afraid people may think you are intoxicated?				
16	Because of your problem, is it difficult for you to walk by yourself?				
17	Does walking down a sidewalk increase your problem?				
18	Because of your problem, is it difficult for you to concentrate?				
19	Because of your problem, is it difficult for you to walk around your house in the dark?				
20	Because of your problem, are you afraid to stay home alone?				
21	Because of your problem, do you feel handicapped?				
22	Has your problem placed stress on your relationships with members of your family or friends?				
23	Because of your problem, are you depressed?				
24	Does your problem interfere with your job or household responsibilities?				
25	Does bending over increase your problem?				
	(Functional_____ 36), (Emotional_____36), (Physical_____28)	**Total**			
		TOTAL(out of 100)	_____100		