CHUGACH
PHYSICAL THERAPY
THERAPIST OWNED & OPERATED

DIZZINESS HANDICAP INVENTORY
(DHI)

Patient Name: _____ Date: _____

The purpose of this questionnaire is to identify difficulties you may be experiencing because of your dizziness. Please circle the 4 for "Always", 2 for "Sometimes" or 0 for "No" to each question. Answer each question only as it pertains currently to your dizziness. There are three categories, Physical, Emotional and Functional which the questions apply to. Your self-assessment will help your Physical Therapist obtain a more complete picture of what you are experiencing due to your dizziness.

Question	Category: Physical	Always (A)	Sometimes (B)	No (C)
1	Does looking up increase your problem?	**4**	**2**	**0**
2	Does walking down the aisle of a supermarket increase your problem?	**4**	**2**	**0**
3	Does performing more ambitious activities like sports, dancing and household chores such as sweeping or putting dishes away increase your problem?	**4**	**2**	**0**
4	Do quick movements of your head increase your problem?	**4**	**2**	**0**
5	Does turning over in bed increase your problem?	**4**	**2**	**0**
6	Does walking down a sidewalk increase your problem?	**4**	**2**	**0**
7	Does bending over increase your problem?	**4**	**2**	**0**
	Category: Emotional			
8	Because of your problem do you feel frustrated?	**4**	**2**	**0**
9	Because of your problem are you afraid to leave your home without having someone accompany you?	**4**	**2**	**0**
10	Because of your problem have you been embarrassed in front of others?	**4**	**2**	**0**
11	Because of your problem are you afraid people may think you are intoxicated?	**4**	**2**	**0**
12	Because of your problem is it difficult for you to concentrate?	**4**	**2**	**0**
13	Because of your problem are you afraid to stay home alone?	**4**	**2**	**0**
14	Because of your problem do you feel handicapped?	**4**	**2**	**0**
15	Has your problem placed stress on your relationships with members of your family or friends?	**4**	**2**	**0**
16	Because of your problem are you depressed?	**4**	**2**	**0**
	Category: Functional			
17	Because of your problem do you restrict your travel for business or recreation?	**4**	**2**	**0**
18	Because of your problem do you have difficulty getting into or out of bed?	**4**	**2**	**0**
19	Does your problem significantly restrict your participation in social activities such as going out to dinner, movies, dancing or parties?	**4**	**2**	**0**
20	Because of your problem do you have difficulty reading?	**4**	**2**	**0**
21	Because of your problem do you avoid heights?	**4**	**2**	**0**
22	Because of your problem is it difficult for you to do strenuous housework or yard work?	**4**	**2**	**0**
23	Because of your problem is it difficult for you to go for a walk by yourself?	**4**	**2**	**0**
24	Because of your problem is it difficult for you to walk around your house in the dark?	**4**	**2**	**0**
25	Does your problem interfere with your job or household responsibilities?	**4**	**2**	**0**
	Column Totals			