imc internal medicine consultants POWERED BY: ReShape PHYSICAL THERAPY

Patient Name: _____ **Date:** _____

DIZZINESS HANDICAP INVENTORY (DHI)

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

		(4)	(2)	(0)
	Questions	Yes	Sometimes	No
P1.	Does looking up increase your problem?	☐	☐	☐
P2.	Because of your problem do you feel frustrated?	☐	☐	☐
P3.	Because of your problem do you restrict your travel for business or recreation?	☐	☐	☐
P4.	Does walking down the aisle of a supermarket increase your problem?	☐	☐	☐
P5.	Because of your problem do you have difficulty getting into or out of bed?	☐	☐	☐
P6.	Does your problem significantly restrict your participation in social activities such as going out to dinner, going to the movies, dancing, or to parties?	☐	☐	☐
P7.	Because of your problem do you have difficulty reading?	☐	☐	☐
P8.	Does performing more ambitious activities like sports, dancing, household chores such as sweeping or putting dishes away increase your problem?	☐	☐	☐
P9.	Because of your problem are you afraid to leave your home without having someone to accompany you?	☐	☐	☐
P10.	Because of your problem have you been embarrassed in front of others?	☐	☐	☐

Page 1 Score: _____

Patient Signature: _____ **Date** _____

Therapist Signature: _____ **Date** _____

Patient Name: _____ **Date:** _____

Question	(4) Yes	(2) Sometimes	(0) No
P11. Do quick movements of your head increase your problem?	☐	☐	☐
P12. Because of your problem do you avoid heights?	☐	☐	☐
P13. Does turning over in bed increase your problem?	☐	☐	☐
P14. Because of your problem, is is difficult for you to do strenuous housework or yardwork?	☐	☐	☐
P15. Because of your problem are you afraid people may think that you are intoxicated?	☐	☐	☐
P16. Because of your problem is it difficult for you to go for a walk by yourself?	☐	☐	☐
P17. Does walking down a sidewalk increase your problem?	☐	☐	☐
P18. Because of your problem is it difficult for you to concentrate?	☐	☐	☐
P19. Because of your problem is it difficult for you to walk around your house in the dark?	☐	☐	☐
P20. Because of your problem are you afraid to stay home alone?	☐	☐	☐
P21. Because of your problem do you feel handicapped?	☐	☐	☐
P22. Has your problem placed stress on your relationship with members of your family or friends?	☐	☐	☐
P23. Because of your problem are you depressed?	☐	☐	☐
P24. Does your problem interfere with your job or household responsibilities?	☐	☐	☐
P25. Does bending over increase your problem?	☐	☐	☐

Page 2 Score: _____

Total Page 1 & 2 Scores: 0

Total DHI Score: 0 (Total Score) = 0 **% dizziness handicap**

Patient Signature: _____ **Date** _____

Therapist Signature: _____ **Date** _____

Submit