

## Dizziness Handicap Inventory (DHI)

### INITIAL VISIT/FOLLOW-UP/DISCHARGE

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

Please mark an "x" in the appropriate box regarding your dizziness/imbalance symptoms.

		YES	SOMETIMES	NO
<b>P1</b>	Does looking up increase your problem?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>E2</b>	Because of your problem, do you feel frustrated?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>F3</b>	Because of your problem, do you restrict your travel for business or recreation?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>P4</b>	Does walking down the aisle of a supermarket increase your problem?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>F5</b>	Because of your problem, do you have difficulty getting into or out of bed?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>F6</b>	Does your problem significantly restrict your participation in social activities, such as going out to dinner, going to the movies, dancing or going to parties?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>F7</b>	Because of your problem, do you have difficulty reading?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>P8</b>	Does performing more ambitious activities, such as sports, dancing, household chores (sweeping or putting dishes away), increase your problem?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>E9</b>	Because of your problem, are you afraid to leave your home without having someone accompany you?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>E10</b>	Because of your problem, have you been embarrassed in front of others?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>P11</b>	Do quick movements of your head increase your problem?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>F12</b>	Because of your problem, do you avoid heights?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>P13</b>	Does turning over in bed increase your problem?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>F14</b>	Because of your problem, is it difficult for you to do strenuous housework or yard work?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>E15</b>	Because of your problem, are you afraid people may think you are intoxicated?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>F16</b>	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"/>
<b>P17</b>	Does walking down a sidewalk increase your problem?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>E18</b>	Because of your problem, is it difficult for you to concentrate?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>F19</b>	Because of your problem, is it difficult for you to walk around your house in the dark?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>E20</b>	Because of your problem, are you afraid to stay home alone?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>E21</b>	Because of your problem, do you feel handicapped?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>E22</b>	Has the problem placed stress on your relationships with your family members or friends?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>E23</b>	Because of your problem, are you depressed?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>F24</b>	Does your problem interfere with your job or household responsibilities?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>P25</b>	Does bending over increase your problem?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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Score P: \_\_\_\_\_ E: \_\_\_\_\_ F: \_\_\_\_\_

16–34 Points (Mild)  
 36–52 Points (Moderate)  
 54+ Points (Severe)