VAUGHAN PHYSIOTHERAPY CLINIC

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Scan for your patient portal: book, forms and receipts

Dizziness Handicap Inventory (DHI)

Get better today.

This questionnaire helps us understand the difficulties your dizziness or unsteadiness may be causing. Answer every question with Yes, Sometimes or No, based on how you have felt over the last month. Please do not skip any.

Patient name *		**Date of birth ***	Y Y Y Y - M M - D D

Dizziness Handicap Inventory

Tick one answer for each question. Your physiotherapist will score it.

Because of your dizziness or unsteadiness...	**Yes**	**Sometimes**	**No**
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 your participation in social activities, such as going out to dinner, going to movies, dancing or to parties?	○	○	○
7. Because of your problem, do you have difficulty reading?	○	○	○
8. Does performing more ambitious activities like sports, dancing, and household chores such as sweeping or putting dishes away increase your 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 go for a 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?	○	○	○

Signature *		**Date ***	Y Y Y Y - M M - D D

Office use: DHI total score (0 to 100) P / E / F		**Reviewed by**	

Office use: Yes = 4, Sometimes = 2, No = 0. P = physical, E = emotional, F = functional.