

APPENDIX 1: DIZZINESS HANDICAP INVENTORY*

The purpose of this scale is to identify difficulties that you may be experiencing because of your dizziness or unsteadiness. Please check "Yes," "No," or "Sometimes" to each question. *Answer each question as it pertains to your dizziness or unsteadiness only.*

	Yes	No	Sometimes
P1. Does looking up increase your problem?	_____	_____	_____
E2. Because of your problem, do you feel frustrated?	_____	_____	_____
F3. 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?	_____	_____	_____
F5. Because of your problem, do you have difficulty getting into or out of bed?	_____	_____	_____
F6. Does your problem significantly restrict your participation in social activities such as going out to dinner, the movies, dancing, or parties?	_____	_____	_____
F7. Because of your problem, do you have difficulty reading?	_____	_____	_____
P8. Does performing more ambitious activities such as sports, dancing, or household chores (sweeping or putting dishes away) increase your problem?	_____	_____	_____
E9. Because of your problem, are you afraid to leave your home without having someone accompany you?	_____	_____	_____
E10. Because of your problem, are you embarrassed in front of others?	_____	_____	_____
P11. Do quick movements of your head increase your problem?	_____	_____	_____
F12. Because of your problem, do you avoid heights?	_____	_____	_____
P13. Does turning over in bed increase your problem?	_____	_____	_____
F14. Because of your problem, is it difficult for you to do strenuous housework or yardwork?	_____	_____	_____
E15. Because of your problem, are you afraid people may think you are intoxicated?	_____	_____	_____
F16. Because of your problem, is it difficult for you to walk by yourself?	_____	_____	_____
P17. Does walking down a sidewalk increase your problem?	_____	_____	_____
E18. Because of your problem, is it difficult for you to concentrate?	_____	_____	_____
F19. Because of your problem, is it difficult for you to walk around your house in the dark?	_____	_____	_____
E20. Because of your problem, are you afraid to stay home alone?	_____	_____	_____
E21. Because of your problem, do you feel handicapped?	_____	_____	_____
E22. Has your problem placed stress on your relationships with members of your family or friends?	_____	_____	_____
E23. Because of your problem, are you depressed?	_____	_____	_____
F24. Does your problem interfere with your job or household responsibilities?	_____	_____	_____
P25. Does bending over increase your problem?	_____	_____	_____
Total	_____	_____	_____
	(4x)	(x0)	(x2)
Total: _____	F _____	E _____	P _____
Maximum (100)	(36)	(36)	(28)

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