Covenant HealthCare
1447 North Harrison
Saginaw, MI 48602

QUESTIONNAIRE / DIZZINESS HANDICAP INVENTORY

PF08860 (R 3/13)

PATIENT I.D.

The purpose of this scale is to identify difficulties that you may be experiencing because of your dizziness. Please mark "always," "sometimes," or "never" by placing an "x" in the box next to each question. **Answer each question with one response as it pertains to your dizziness or balance problem only.**

	Question		Always	Sometimes	Never
1.	Does looking up increase your problem?	**P**			
2.	Because of your problem, do you feel frustrated?	**E**			
3.	Because of your problem, do you restrict your travel for business or recreation?	**F**			
4.	Does walking down the aisle of a supermarket increase your problem?	**P**			
5.	Because of your problem, do you have difficulty getting into or out of bed?	**F**			
6.	Does your problem significantly restrict your participation in social activities such as going out to dinner, going to the movies, dancing or to parties?	**F**			
7.	Because of your problem, do you have difficulty reading?	**F**			
8.	Does performing more ambitious activities like sports, dancing, household chores such as sweeping or putting dishes away increase your problem?	**P**			
9.	Because of your problem, are you afraid to leave your home without someone accompanying you?	**E**			
10.	Because of your problem, have you been embarrassed in front of others?	**E**			
11.	Do quick movements to your head increase your problem?	**P**			
12.	Because of your problem, do you avoid heights?	**F**			
13.	Does turning over in bed increase your problem?	**P**			
14.	Because of your problem, is it difficult for you to do strenuous housework or yardwork?	**F**			
15.	Because of your problem, are you afraid people may think you are intoxicated?	**E**			

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	Question		Always	Sometimes	Never
16.	Because of your problem, is it difficult for you to go for a walk by yourself?	**F**			
17.	Does walking down a sidewalk increase your problem?	**P**			
18.	Because of your problem, is it difficult for you to concentrate?	**E**			
19.	Because of your problem, is it difficult to walk around your house in the dark?	**F**			
20.	Because of your problem, are you afraid to stay home alone?	**E**			
21.	Because of your problem, do you feel handicapped?	**E**			
22.	Has your problem placed stress on your relationships with members of your family or friends?	**E**			
23.	Because of your problem, are you depressed?	**E**			
24.	Does your problem interfere with your job or household responsibilities?	**F**			
25.	Does bending over increase your problem?	**P**			
			x 4	x 2	x 0
	TOTAL				

P _____ E _____ F _____
Physical Subscale Emotional Subscale Functional Subscale

Score: _____ (Physical + Emotional + Functional subscale = Total Score)
Interpretation:
100-70 = severe perception of having a handicap
69-40 = moderate perception of handicap
39-0 = low perception of handicap

Patient Signature: _____

Therapist Signature: _____

Date: _____