TOEPPERWEIN PHYSICAL THERAPY & Spine Rehab

| Dizziness Handicap Inventory | | Please mark only 1 box for each area | | |
|---|---|---|---|---|
| Does looking up increase your problem? | P | ☐ Yes | ☐ No | ☐ Sometimes |
| Because of your problem, do you feel frustrated? | E | ☐ Yes | ☐ No | ☐ Sometimes |
| Because of your problem, do you restrict your travel for business or recreation? | F | ☐ Yes | ☐ No | ☐ Sometimes |
| Does walking down the aisle of a supermarket increase your problem? | P | ☐ Yes | ☐ No | ☐ Sometimes |
| Because of your problem, do you have difficulty getting in or out of bed? | F | ☐ Yes | ☐ No | ☐ Sometimes |
| Does your problem significantly restrict your participation in social activities such as going out to dinner, the movies, dancing or to parties? | F | ☐ Yes | ☐ No | ☐ Sometimes |
| Because of your problem, do you have difficulty reading? | F | ☐ Yes | ☐ No | ☐ Sometimes |
| Does performing more ambitious activities such as sports or dancing or household chores such as sweeping or putting dishes away increase your problem? | P | ☐ Yes | ☐ No | ☐ Sometimes |
| Because of your problem, are you afraid to leave your home without having someone accompany you? | E | ☐ Yes | ☐ No | ☐ Sometimes |
| Because of your problem, are you embarrassed in front of others? | E | ☐ Yes | ☐ No | ☐ Sometimes |
| Do quick movements of your head increase your problem? | P | ☐ Yes | ☐ No | ☐ Sometimes |
| Because of your problem, do you avoid heights? | F | ☐ Yes | ☐ No | ☐ Sometimes |
| Does turning over in bed increase our problem? | P | ☐ Yes | ☐ No | ☐ Sometimes |
| Because of your problem, is it difficult for you to do strenuous housework or yard work? | F | ☐ Yes | ☐ No | ☐ Sometimes |
| Because of your problem, are you afraid people may think you are intoxicated? | E | ☐ Yes | ☐ No | ☐ Sometimes |
| Because of your problem, is it difficult for you to walk by yourself? | F | ☐ Yes | ☐ No | ☐ Sometimes |
| Does walking down a sidewalk increase your problem? | P | ☐ Yes | ☐ No | ☐ Sometimes |
| Because of your problem, is it difficult for you to concentrate? | E | ☐ Yes | ☐ No | ☐ Sometimes |
| Because of your problem, is it difficult for you to walk around the house in the dark? | F | ☐ Yes | ☐ No | ☐ Sometimes |
| Because of your problem, are you afraid to stay at home alone? | E | ☐ Yes | ☐ No | ☐ Sometimes |
| Because of your problem, do you feel handicapped? | E | ☐ Yes | ☐ No | ☐ Sometimes |
| Has your problem placed stress on your relationship with members of your family or friends? | E | ☐ Yes | ☐ No | ☐ Sometimes |
| Because of your problem, are you depressed? | E | ☐ Yes | ☐ No | ☐ Sometimes |
| Does your problem interfere with your job or household responsibilities? | F | ☐ Yes | ☐ No | ☐ Sometimes |
| Does bending over increase your problem? | P | ☐ Yes | ☐ No | ☐ Sometimes |
| | | X 4 | | |
| | | | X 0 | X 2 |

Total P:_____ Total E:_____ Total F:_____

☐ 100-70 = severe perception of having a handicap ☐ 69-40= moderate perception of handicap ☐ 39-0 low perception of handicap

Name:_____ Date:_____