Willow Grove Physical Therapy

Patient Name:_____
MR#: _____
Account#:_____
Initial Discharge

DIZZINESS HANDICAP INVENTORY

Please answer the following questions regarding difficulties that you may be experiencing because of dizziness or unsteadiness. For each question, please place a check mark in the box that most closely describes your problem.

	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, the movies, dancing or to parties?			
7. Because of your problem do you have difficulty reading?			
8. Does performing more ambitious activities like sports or dancing or 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 to accompany you?			
10. Because of your problem are you embarrassed in front of others?			
11. Do quick movement of your head increase your Problem?			

→

	Yes	Sometimes	No
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 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?			

FOR OFFICE USE ONLY

Total_____ F _____ E _____ P_____

(38) (36) (28)