Access Rehab Centers
A Waterbury Hospital & Easterseals Partnership in Physical Rehabilitation

DIZZINESS HANDICAP INVENTORY

Name: _____ Patient # _____
DOB: _____ Today's Date : _____

Instructions: The purpose of these questions is to identify difficulties that you may be experiencing because of your dizziness. Please answer "yes", "no", or "sometimes" to each question. Answer each question as it pertains to your dizziness or balance problem only.

	QUESTION	YES	SOMETIMES	NO
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, going to the movies, dancing or to parties?			
F7	Because of your problem, do you have difficulty reading?			
F8	Does performing more ambitious activities like sports, dancing, household chores such as 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, have you been 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 to go for a walk by yourself?			
P17	Does walking down a sidewalk increase your problem?			

	QUESTION	YES	SOMETIMES	NO
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 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?			

Instructions: Please check the box for the correct response.

1. I have dizziness/unsteadiness:
   - ☐ More than 1 per week
   - ☐ More than 1 but less than 4 per month
   - ☐ 1 per month
   - ☐ None
2. My dizziness/unsteadiness is: ☐Mild ☐ Moderate ☐ Severe ☐None

Please tell us how satisfied you are with the following aspects of your therapy program here at Access Rehab Centers.

	Very Satisfied	Somewhat Satisfied	Neutral	Somewhat Dissatisfied	Very Dissatisfied
Quality of interaction with clinicians/staff.					
Overall appearance of the facility.					
Overall results.					
Overall involvement in the treatment plan.					
	Definitely Would	Probably Would	Probably Would Not	Definitely Would Not	
Would you recommend our services to a friend?					