Patient Name:_____ Date:_____

Dizziness Handicap Inventory (Youth Version)

INSTRUCTIONS: Please CIRCLE the correct response:

1. I have dizziness/unsteadiness: (1) 1 per month (2) >1 but < 4 per month (3) more than one per week
2. My dizziness/unsteadiness is: (1) mild (2) moderate (3) severe

Please read carefully: The purpose of the scale is to identify difficulties that you may be experiencing because of your dizziness/unsteadiness. Please check off "YES", "SOMETIMES", or "NO" to each item. Answer each question as it pertains to your dizziness/unsteadiness only.

	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 play, getting together with friends, sports, or attendance at school?			
P4. Does walking in the hallways at school increase your problem?			
F5. Because of your problem, do you have difficulty getting into and 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, the mall or parties?			
F7. Because of your problem, do you have difficulty reading?			
P8. Does performing more ambitious activities such as sports, dancing, 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 with 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 activity such as carrying your backpack, or performing light exercise?			
E15. Because of your problem, do you feel like friends notice you are not able to walk straight without weaving?			
F16. Because of your problem, is it difficult for you to go for a walk by yourself?			
P17. Does walking down a sidewalk or on uneven surfaces 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 in the dark?			
E20. Because of your problem, are you afraid to stay home alone?			
E21. Because of your problem, do you feel unable to participate in things your friends are doing?			
E22. Has the problem placed stress on your relationships with members of your family and friends?			
E23. Because of your problem, are you sad?			
F24. Does your problem interfere with your schoolwork or household responsibilities?			
P25. Does bending over increase your problem?			

For Office Use Only:

P _____ E _____ F _____ Total Score: _____