



## DIZZINESS QUESTIONNAIRE

		YES	NO	SOMETIMES
<b>P1</b>	Does looking up increase your problem?			
<b>E2</b>	Because of your problem, do you feel frustrated?			
<b>F3</b>	Because of your problem, do you restrict your travel for business or recreation?			
<b>P4</b>	Does walking down the aisle of a supermarket increase your problem?			
<b>F5</b>	Because of your problem, do you have difficulty getting into or out of bed?			
<b>F6</b>	Does your problem significantly restrict your participation in social activities such as going to movies, dinner, dancing, parties?			
<b>F7</b>	Because of your problem, do you have difficulty reading?			
<b>P8</b>	Do your more ambitious activities like sports, dancing, household chores such as sweeping, putting dishes away, increase your problem?			
<b>E9</b>	Because of your problem, are you afraid to leave your home without having someone accompany you?			
<b>E10</b>	Because of your problem, have you been embarrassed in front of others?			
<b>P11</b>	Do quick movements of your head increase your problem?			
<b>F12</b>	Because of your problem, do you avoid heights?			
<b>P13</b>	Does turning over in bed increase your problem?			
<b>F14</b>	Because of your problem, is it difficult for you to do strenuous housework or yard work?			
<b>E15</b>	Because of your problem, are you afraid people may think you are intoxicated?			
<b>F16</b>	Because of your problem, is it difficult for you to go for a walk by yourself?			
<b>P17</b>	Does walking down a sidewalk increase your problem?			
<b>E18</b>	Because of your problem, is it difficult for you to concentrate?			
<b>F19</b>	Because of your problem, is it difficult for you to walk around your house in the dark?			
<b>E20</b>	Because of your problem, are you afraid to stay home alone?			
<b>E21</b>	Because of your problem, do you feel handicapped?			
<b>E22</b>	Has your problem placed stress on your relationships with members of your family or friends?			
<b>E23</b>	Because of your problem, are you depressed?			
<b>F24</b>	Does your problem interfere with your job or household responsibilities?			
<b>P25</b>	Does bending over increase your problem?			
<b>Totals</b>		X4		X2
<b>Sub-total Score=</b>				
<b>Name:</b>	<b>Date:</b>	<b>TOTAL SCORE=</b>		

"Dizziness Handicap Index" Jacobson, Newman; Arch Otolaryngol Head Neck Surg 116:424.1990  
 100-70= severe perception of having a handicap, 69-40= moderate perception of handicap, 39-0= low perception of handicap.

PLEASE COMPLETE BACK PAGE —————→

## DIZZINESS INDEX

Please circle the number indicating your level of dizziness **currently**:

**0**    **1**    **2**    **3**    **4**    **5**    **6**    **7**    **8**    **9**    **10**  
|    |    |    |    |    |    |    |    |    |  
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**0**= No symptoms

**1**= Tolerable symptoms

**2**= Minimal symptoms, can be ignored

**3**= Symptoms cannot be ignored, but can be tolerated, minimal activity interference

**4**= Symptoms occasionally interferes with activities.

**5**= Symptoms interferes with activities 25% of the time

**6**= Symptoms interferes with activities 50% of the time

**7**= Symptoms interferes with activities 75% of the time

**8**= Symptoms continuously interferes with activities

**9**= Intolerable symptoms, unable to perform all activities except basic needs of eating, toileting

**10**= Intolerable symptoms, unable to perform all activities and have limitations in all tasks, hospitalization required.

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*This item for Follow Up/Discharge Visit Only*

## DIZZINESS INDEX

Please circle the percentage of your improvement since beginning therapy:

**0**    **10**    **20**    **30**    **40**    **50**    **60**    **70**    **80**    **90**    **100**  
|    |    |    |    |    |    |    |    |    |  
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No improvement

Complete recovery