

Patient: _____

Age: _____

DOB: ____/____/____

HEADACHE DISABILITY INDEX

INSTRUCTIONS: Please CIRCLE the correct response:

1. I have headache: [1] 1 per month [2] more than but less than 4 per month [3] more than one per week.
 2. My headache is: [1] mild [2] moderate [3] severe

INSTRUCTIONS: PLEASE READ CAREFULLY: The purpose of the scale is to identify difficulties that you may be experiencing because of your headache. Please check off "YES", "SOMETIMES", or "NO" to each item. Answer each item as it pertains to your headache only.

	YES	SOMETIMES	NO
E1. Because of my headaches I feel handicapped.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
F2. Because of my headaches I feel restricted in performing my routine daily activities.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
E3. No one understands the effect my headaches have on my life.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
F4. I restrict my recreational activities (e.g. sports, hobbies) because of my headaches.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
E5. My headaches make me angry.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
E6. Sometimes I feel that I am going to lose control because of my headaches	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
F7. Because of my headaches I am less likely to socialize.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
E8. My spouse/significant other, or family and friends have no idea what I am going through because of my headaches.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
E9. My headaches are so bad that I feel I am going to go insane.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
E10. My outlook on the world is affected by my headaches.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
E11. I am afraid to go outside when I feel a headache is starting.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
E12. I feel desperate because of my headaches.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
F13. I am concerned that I am paying penalties at work or at home because of my headaches.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
E14. My headaches place stress on my relationships with family or friends.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
F15. I avoid being around people when I have a headache.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
F16. I believe my headaches are making it difficult for me to achieve my goals in life.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
F17. I am unable to think clearly because of my headaches.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
F18. I get tense (e.g. muscle tension) because of my headaches.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
F19. I do not enjoy social gatherings because of my headaches.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
E20. I feel irritable because of my headaches.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
F21. I avoid traveling because of my headaches.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
E22. My headaches make me feel confused.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
E23. My headaches make me feel frustrated.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
F24. I find it difficult to read because of my headaches.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
F25. I find it difficult to focus my attention away from my headaches and on other things.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Reference: Jacobson Gary P., Ramadan NM, et al., The Henry Ford Hospital Headache Disability Inventory (HDI). Neurology 1994; 44:837-842

MCC USE ONLY: Scoring
 Total: ____; E ____; F ____
 (100) (52) (48)

Patient Signature: _____

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DIZZINESS HANDICAP INVENTORY

Most practices that evaluate substantial numbers of dizzy patients use questionnaires to quantify symptoms. One of the most commonly used "standardized questionnaires" is the Dizziness Handicap Inventory (DHI) developed by Dr. G.P. Jacobson and Dr. C.W. Newman, 1990.

Instructions: Answer Yes, No, or Sometimes for each question.

	Yes	No	Sometimes
1. Does looking up increase your problem?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Because of your problem, do you feel frustrated?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Because of your problem, do you restrict your travel for business or recreation?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Does walking down the aisle of a supermarket increase your problem?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Because of your problem, do you have difficulty getting into or out of bed?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Does your problem significantly restrict your participation in social activities such as going out to dinner, going to movies, dancing, or to parties?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Because of your problem, do you have difficulty reading?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Does performing more ambitious activities like sports, dancing, household chores such as sweeping or putting dishes away increase your problem?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Because of your problem, are you afraid to leave your home without having some one accompany you?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. Because of your problem, have you been embarrassed in front of others?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. Do quick movements of your head increase your problem?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12. Because of your problem, do you avoid heights?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13. Does turning over in bed increase your problem?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14. Because of your problem, is it difficult for you to do strenuous housework or yard work?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
15. Because of your problem, are you afraid people may think you are intoxicated?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
16. Because of your problem, is it difficult for you to walk by yourself?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
17. Does walking down a sidewalk increase your problem?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
18. Because of your problem, is it difficult for you to concentrate?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
19. Because of your problem, is it difficult for you to walk around your house in the dark?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
20. Because of your problem, are you afraid to stay home alone?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
21. Because of your problem, do you feel handicapped?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
22. Has your problem placed stress on your relationships with members of your family or friends?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
23. Because of your problem, are you depressed?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
24. Does your problem interfere with your job or household responsibilities?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
25. Does bending over increase your problem?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

The Dizziness Handicap Inventory (DHI) is a 25-item self-assessment scale. A "yes" response to an item is awarded 4 points, a "sometimes" 2 points, and a "no", 0 points. Possible scores on the DHI range from 0 (suggesting no handicap) to 100, indicating significant perceived handicap (Jacobson and Newman, 1999).

MCC USE ONLY:
SCORE: _____

Patient Signature _____

Date ____/____/____