Participant #_____
Assessment #_____
Date_____

HEART FAILURE SOMATIC AWARENESS SCALE

Think about how you have felt in the PAST WEEK.

Circle the number that tells how much the symptom bothered you.

Please respond to each statement.

	I did **NOT** have this symptom	Not at all Bothersome	Slightly Bothersome	Moderately Bothersome	Quite a bit Bothersome	Extremely Bothersome
1. I could feel my heart beat get faster	0	1	2	3	4	5
2. I could not breathe if I lay down (flat).	0	1	2	3	4	5
3. I felt discomfort or pain in my chest	0	1	2	3	4	5
4. I had an upset stomach	0	1	2	3	4	5
5. I had a cough	0	1	2	3	4	5
6. I was tired	0	1	2	3	4	5

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	I did **NOT** have this symptom	Not at all Bothersome	Slightly Bothersome	Moderately Bothersome	Quite a bit Bothersome	Extremely Bothersome
7. I could not catch my breath	0	1	2	3	4	5
8. My feet were swollen at the end of the day	0	1	2	3	4	5
9. I woke up at night because I could not breathe	0	1	2	3	4	5
10. My shoes were tighter than usual at the end of the day	0	1	2	3	4	5
11. I gained weight in the past week	0	1	2	3	4	5
12. I could not do my usual activities because I was short of breath	0	1	2	3	4	5

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	I did **NOT** have this symptom	Not at all Bothersome	Slightly Bothersome	Moderately Bothersome	Quite a bit Bothersome	Extremely Bothersome
13. Getting dressed made it hard to breathe	0	1	2	3	4	5
14. My clothes felt tighter around my waist	0	1	2	3	4	5
15. I woke up at night because I had to urinate	0	1	2	3	4	5
16. I had to rest more than usual during the day	0	1	2	3	4	5
17. It was hard for me to breathe	0	1	2	3	4	5
18. I did not feel like eating	0	1	2	3	4	5

THANK YOU

HF Somatic Perception Scale