

Gottman Feelings Wheel

Date:

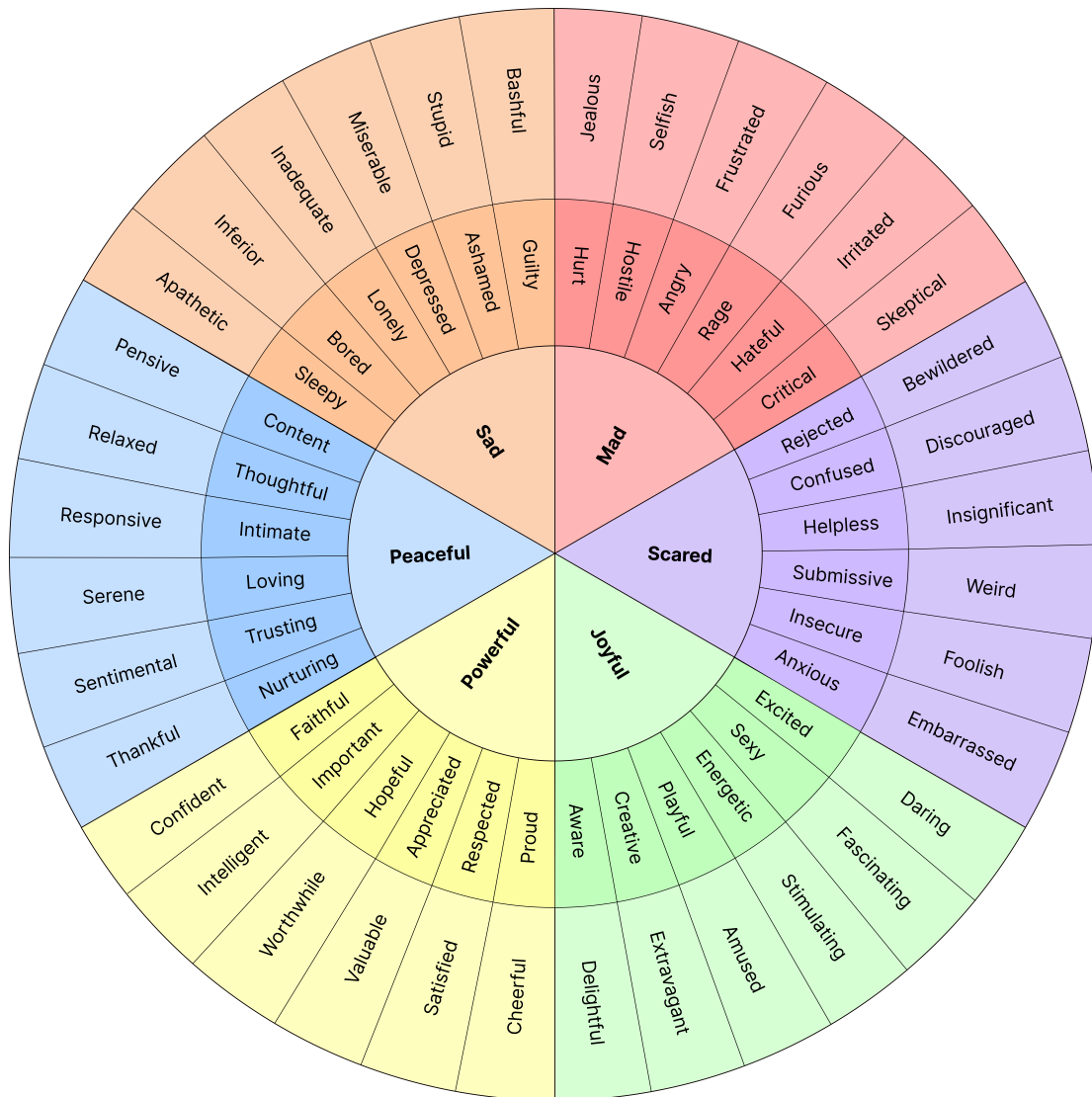
Patient's Name:

Date of Birth:

Gender:

Medical History (if needed):

Referring Physician:



Notes: