Gottman Feelings Wheel

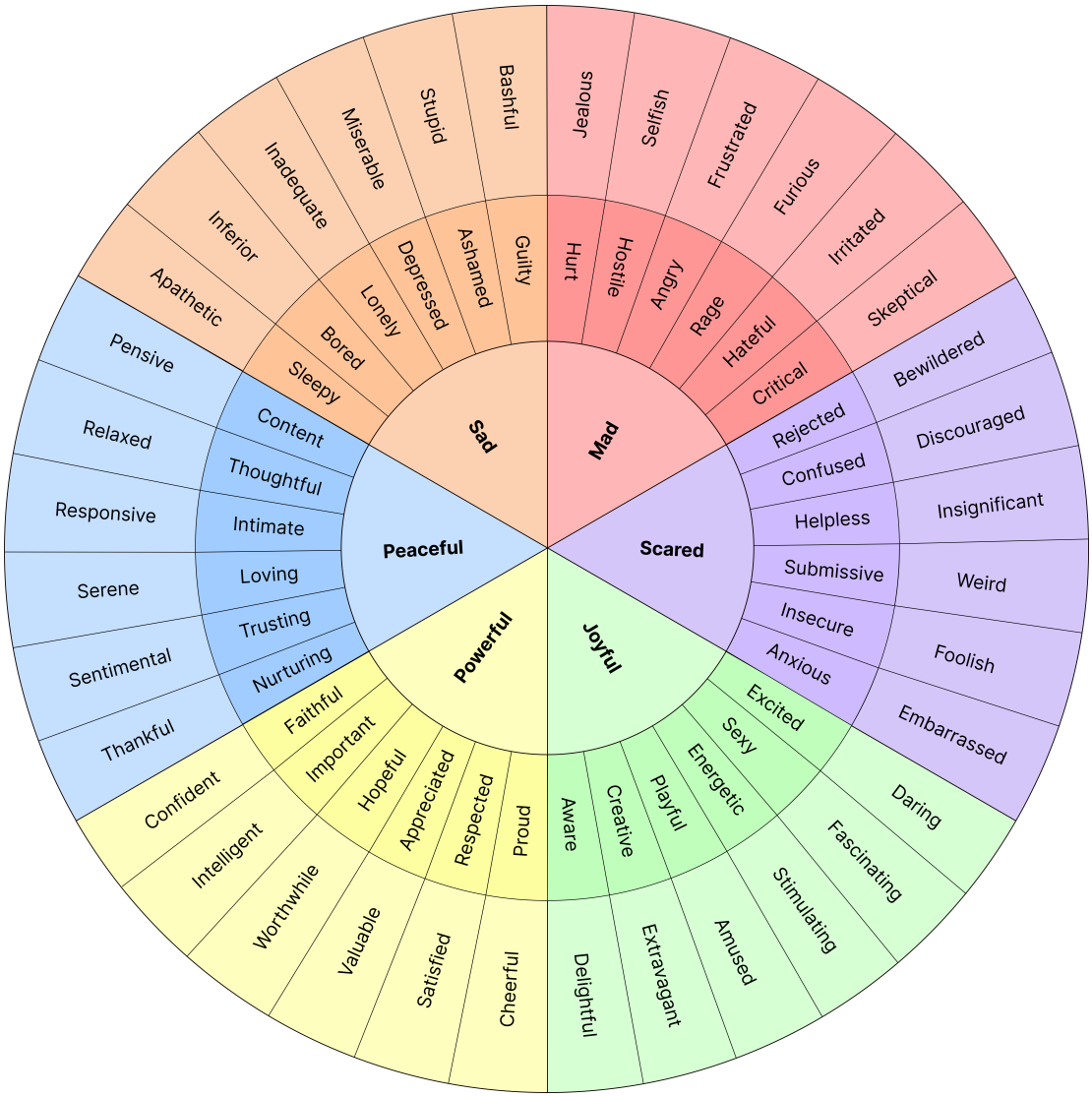
Date:

Patient's Name:

Date of Birth: **Gender:**

Medical History (if needed):

Referring Physician:



Notes: