Form 5- Psychological/Physiological Cases

Case Number:		Witness:	

Witness: Please Include Written Personal Account On Form 1

Include Details On The Items Checked Below

Psychological Effects

Circle D (DURING) And/Or A (AFTER) Beside Each Checked Item To Indicate Whether The Effect Occurred DURING or AFTER The Sighting Event. Additional Information (including the time duration of each effect) Should Be Included In Your Written Account Of Your UFO Sighting Experience. Use Additional Sheets As Necessary To Include As Much Detail As Possible.

Calmness : ( ) D A	Thinking Impaired : ( ) D A	Religious Experience : ( ) D A
Curious : ( ) D A	Trance-Like State : ( ) D A	Personality Change : ( ) D A
Elation : ( ) D A	Memory Lapse : ( ) D A	Mental Telepathy : ( ) D A
Dreams : ( ) D A	Nightmares : ( ) D A	Fear / Dread : ( ) D A
Panicked : ( ) D A	Involuntary Actions : ( ) D A	_____ :( ) D A

Comments:

Did You Seek Therapy ? _____ Name Of Therapist :

Address:

City, ST, Zip:

Physiological Effects (During-D) or (After-A)

Hair Burned : ( ) D A	Hair Turned White : ( ) D A	Tooth Filling Vibrated : ( ) D A
Felt Dizzy : ( ) D A	Felt Electric Shock : ( ) D A	Experienced Body Marks : ( ) D A
Ears Hurt : ( ) D A	Body Perspired : ( ) D A	Experienced Body Wounds :( ) D A
Nose Bleed : ( ) D A	Floated In The Air : ( ) D A	Experienced Skin Rash : ( ) D A
Vomited : ( ) D A	Shook Nervously : ( ) D A	Felt Weak / Sluggish : ( ) D A
Passed Urine : ( ) D A	Skin Was Burned : ( ) D A	Skin Was Peeled Off : ( ) D A
Passed Stool : ( ) D A	Became Paralyzed : ( ) D A	Spinal Column Ached : ( ) D A
Felt Warmer : ( ) D A	Experienced Warts : ( ) D A	Felt Burning Sensation : ( ) D A
Felt Colder : ( ) D A	Organs Vibrated : ( ) D A	Experienced Dry Heaves : ( ) D A
Felt Lighter : ( ) D A	Felt Nauseated : ( ) D A	Neck Muscles Ached : ( ) D A
Felt Heavier : ( ) D A	Eyes Out Of Focus : ( ) D A	Arm Muscles Ached : ( ) D A
Had Headache : ( ) D A	Eyes Watered : ( ) D A	Leg Muscles Ached : ( ) D A
Was Blinded : ( ) D A	Eardrums Vibrated : ( ) D A	Eyes Burned / Hurt : ( ) D A
Was Deafened : ( ) D A	Bled Through Mouth : ( ) D A	Hair Stood On End : ( ) D A
Hair Fell Out : ( ) D A	Nose Irritated : ( ) D A	Strange Taste In Mouth : ( ) D A
_____ : ( ) D A	_____ : ( ) D A	_____ ( ) D A

Comments:

Did You Seek Treatment ? _____ Name Of Doctor :

Address:

City, State, Zip:

Lasting Effects

Describe Any Of The Effects Checked Above Which Still Exist Or Have Worsened:

Relationship Of UFO Or Entity To Affected Person

Indirect:	UFO Merely Overflew Area With No Apparent Interest In Witness : (
Apparent Direct:	UFO Approached Witness During Effects : ( ) UFO Hovered Over Witness During Effects : ( )
Actual Direct:	Witness Touched By : UFO: ( ) Light Beam: ( ) Entity: ( ) An Instrument: ( )
Comments:	

Psychic Interests And Abilities

Interest In Psychic Phenomena?	Yes ( ) No ( )		What Type :
Do You Psychic Abilities?	Yes ( ) No ( )		Describe :
Have Abilities Been Tested?	Yes ( ) No ( )		By Whom / Results:
Comments :			

Investigator Additional Notes, Comments, Remarks

(Investigator)

Acquire RECORDS Any Medical Treatment Or Therapeutic Treatment As May Be Available To Complete This Case Investigation.

Photograph Any Visible Injuries And / Or Scars Present On The Witness(es). Include A Ruler In The Photo To Show Scale.

I authorize MUFON to receive copies of all my medical treatment records relating to this investigation: Yes ( ) No ( )

I authorize MUFON to receive copies of all my therapeutic treatment records relating to this investigation: Yes ( ) No ( )

You May ( ) , May Not ( ) Use My Name In Conjunction With This Report.

Witness Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____