



Psychological/Physiological Cases

MUFON Form 5 (Page 1 of 2)

Case Number: _____

Witness: _____

Witness: Include Written Personal Account On Form 1
Include Details On The Items Checked Below

Circle the D And/Or A Beside Each Item Checked 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.

Psychological Effects (Check All that Apply)

None : <input type="checkbox"/> <u>D</u> <input type="checkbox"/> <u>A</u>	Thinking Impaired : <input type="checkbox"/> <u>D</u> <input type="checkbox"/> <u>A</u>	Personality Change : <input type="checkbox"/> <u>D</u> <input type="checkbox"/> <u>A</u>
Calmness : <input type="checkbox"/> <u>D</u> <input type="checkbox"/> <u>A</u>	Trance-Like State : <input type="checkbox"/> <u>D</u> <input type="checkbox"/> <u>A</u>	Mental Telepathy : <input type="checkbox"/> <u>D</u> <input type="checkbox"/> <u>A</u>
Curious : <input type="checkbox"/> <u>D</u> <input type="checkbox"/> <u>A</u>	Memory Lapse : <input type="checkbox"/> <u>D</u> <input type="checkbox"/> <u>A</u>	Fear / Dread : <input type="checkbox"/> <u>D</u> <input type="checkbox"/> <u>A</u>
Elation / Love : <input type="checkbox"/> <u>D</u> <input type="checkbox"/> <u>A</u>	Nightmares : <input type="checkbox"/> <u>D</u> <input type="checkbox"/> <u>A</u>	Precognition : <input type="checkbox"/> <u>D</u> <input type="checkbox"/> <u>A</u>
Dreams : <input type="checkbox"/> <u>D</u> <input type="checkbox"/> <u>A</u>	Involuntary Actions : <input type="checkbox"/> <u>D</u> <input type="checkbox"/> <u>A</u>	Other: _____ : <input type="checkbox"/> <u>D</u> <input type="checkbox"/> <u>A</u>
Panicked : <input type="checkbox"/> <u>D</u> <input type="checkbox"/> <u>A</u>	Obsession : <input type="checkbox"/> <u>D</u> <input type="checkbox"/> <u>A</u>	Other: _____ : <input type="checkbox"/> <u>D</u> <input type="checkbox"/> <u>A</u>
Insomnia : <input type="checkbox"/> <u>D</u> <input type="checkbox"/> <u>A</u>	Religious Experience : <input type="checkbox"/> <u>D</u> <input type="checkbox"/> <u>A</u>	Unknown : <input type="checkbox"/> <u>D</u> <input type="checkbox"/> <u>A</u>

Comments: _____
 Did You Seek Therapy ? Yes No Name Of Therapist : _____

Physiological Effects (Check All That Apply)

None : <input type="checkbox"/> <u>D</u> <input type="checkbox"/> <u>A</u>	Hair Stood on End : <input type="checkbox"/> <u>D</u> <input type="checkbox"/> <u>A</u>	Experienced Skin Rash : <input type="checkbox"/> <u>D</u> <input type="checkbox"/> <u>A</u>
Felt Dizzy : <input type="checkbox"/> <u>D</u> <input type="checkbox"/> <u>A</u>	Hair Turned White : <input type="checkbox"/> <u>D</u> <input type="checkbox"/> <u>A</u>	Experienced Warts : <input type="checkbox"/> <u>D</u> <input type="checkbox"/> <u>A</u>
Experienced Dry Heaves : <input type="checkbox"/> <u>D</u> <input type="checkbox"/> <u>A</u>	Hair Fell Out : <input type="checkbox"/> <u>D</u> <input type="checkbox"/> <u>A</u>	Experienced Body Marks : <input type="checkbox"/> <u>D</u> <input type="checkbox"/> <u>A</u>
Vomited : <input type="checkbox"/> <u>D</u> <input type="checkbox"/> <u>A</u>	Hair Burned : <input type="checkbox"/> <u>D</u> <input type="checkbox"/> <u>A</u>	Experienced Body Wounds : <input type="checkbox"/> <u>D</u> <input type="checkbox"/> <u>A</u>
Passed Urine : <input type="checkbox"/> <u>D</u> <input type="checkbox"/> <u>A</u>	Eyes Out of Focus : <input type="checkbox"/> <u>D</u> <input type="checkbox"/> <u>A</u>	Felt Tired / Fatigued : <input type="checkbox"/> <u>D</u> <input type="checkbox"/> <u>A</u>
Passed Stool : <input type="checkbox"/> <u>D</u> <input type="checkbox"/> <u>A</u>	Eyes Watered : <input type="checkbox"/> <u>D</u> <input type="checkbox"/> <u>A</u>	Felt Weak / Sluggish : <input type="checkbox"/> <u>D</u> <input type="checkbox"/> <u>A</u>
Felt Warmer : <input type="checkbox"/> <u>D</u> <input type="checkbox"/> <u>A</u>	Eyes Burned / Hurt : <input type="checkbox"/> <u>D</u> <input type="checkbox"/> <u>A</u>	Felt Burning Sensation : <input type="checkbox"/> <u>D</u> <input type="checkbox"/> <u>A</u>
Felt Colder : <input type="checkbox"/> <u>D</u> <input type="checkbox"/> <u>A</u>	Was Blinded : <input type="checkbox"/> <u>D</u> <input type="checkbox"/> <u>A</u>	Skin Was Peeled Off : <input type="checkbox"/> <u>D</u> <input type="checkbox"/> <u>A</u>
Felt Lighter : <input type="checkbox"/> <u>D</u> <input type="checkbox"/> <u>A</u>	Nose Irritated : <input type="checkbox"/> <u>D</u> <input type="checkbox"/> <u>A</u>	Skin Was Burned : <input type="checkbox"/> <u>D</u> <input type="checkbox"/> <u>A</u>
Felt Heavier : <input type="checkbox"/> <u>D</u> <input type="checkbox"/> <u>A</u>	Nose Bleed : <input type="checkbox"/> <u>D</u> <input type="checkbox"/> <u>A</u>	Neck Muscles Ached : <input type="checkbox"/> <u>D</u> <input type="checkbox"/> <u>A</u>
Felt Burning Sensation : <input type="checkbox"/> <u>D</u> <input type="checkbox"/> <u>A</u>	Was Deafened : <input type="checkbox"/> <u>D</u> <input type="checkbox"/> <u>A</u>	Arm Muscles Ached : <input type="checkbox"/> <u>D</u> <input type="checkbox"/> <u>A</u>
Body Perspired : <input type="checkbox"/> <u>D</u> <input type="checkbox"/> <u>A</u>	Ears Hurt : <input type="checkbox"/> <u>D</u> <input type="checkbox"/> <u>A</u>	Leg Muscles Ached : <input type="checkbox"/> <u>D</u> <input type="checkbox"/> <u>A</u>
Body Temperature Change : <input type="checkbox"/> <u>D</u> <input type="checkbox"/> <u>A</u>	Ear Drums Vibrated : <input type="checkbox"/> <u>D</u> <input type="checkbox"/> <u>A</u>	Spinal Column Ached : <input type="checkbox"/> <u>D</u> <input type="checkbox"/> <u>A</u>
Shook Nervously : <input type="checkbox"/> <u>D</u> <input type="checkbox"/> <u>A</u>	Organs Vibrated : <input type="checkbox"/> <u>D</u> <input type="checkbox"/> <u>A</u>	Motor Skills Affected : <input type="checkbox"/> <u>D</u> <input type="checkbox"/> <u>A</u>
Numbness : <input type="checkbox"/> <u>D</u> <input type="checkbox"/> <u>A</u>	Tooth Filling Vibrated : <input type="checkbox"/> <u>D</u> <input type="checkbox"/> <u>A</u>	Joint / Muscle Stiffness : <input type="checkbox"/> <u>D</u> <input type="checkbox"/> <u>A</u>
Sleep Disorder : <input type="checkbox"/> <u>D</u> <input type="checkbox"/> <u>A</u>	Strange Taste In Mouth : <input type="checkbox"/> <u>D</u> <input type="checkbox"/> <u>A</u>	Experienced Paralysis : <input type="checkbox"/> <u>D</u> <input type="checkbox"/> <u>A</u>
Headache : <input type="checkbox"/> <u>D</u> <input type="checkbox"/> <u>A</u>	Bled Through Mouth : <input type="checkbox"/> <u>D</u> <input type="checkbox"/> <u>A</u>	Other: _____ : <input type="checkbox"/> <u>D</u> <input type="checkbox"/> <u>A</u>
Levitation : <input type="checkbox"/> <u>D</u> <input type="checkbox"/> <u>A</u>	Felt Electric Shock : <input type="checkbox"/> <u>D</u> <input type="checkbox"/> <u>A</u>	Unknown : <input type="checkbox"/> <u>D</u> <input type="checkbox"/> <u>A</u>

Comments: _____
 Did You Seek Treatment ? Yes No Name Of Doctor : _____

Lasting Effects

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



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Relationship Of UFO Or Entity To Affected Person

Indirect : UFO Merely Overflow 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 Have Psychic Abilities? Yes () No () Describe : _____
 Have Abilities Been Tested? Yes () No () By Whom / Results? _____
 Comments : _____

Investigator Additional Notes, Comments, Remarks

Names Of Other Witnesses. Have Psychological Or Physiological Affects? Yes () No () Describe Below:

(Investigator)

Acquire Any Medical Treatment Or Therapeutic Records 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: _____