



UFO SIGHTING QUESTIONNAIRE - PSYCHOLOGICAL/PHYSIOLOGICAL CASES (FORM 5)

INTER-FORM CROSS-REFERENCE DATA

SIGHTING DATE: _____ PLACE: _____
TIME/EFFECTS OCCURRED: FROM _____ TO _____
WITNESS' NAME: _____
INVESTIGATOR'S NAME: _____

GENERAL DATA

TYPE OF EFFECT: PSYCHOLOGICAL () PHYSIOLOGICAL () TEMPORARY () LASTING ()
INGESTION OF: STIMULANT/DEPRESSANT _____ MIN () HRS () PRIOR EFFECT
ATTENDING DOCTOR: (Name/Address/Phone/Comments) _____

PERSONAL ACCOUNT (Include on Form 1)

In your own words, describe any psychological/physiological effects experienced.

PSYCHOLOGICAL EFFECTS

(Circle the D and/or A beside each item checked to denote whether the effect was noted during or after the UFO sighting. Additional information, including the time duration of each effect, should be clearly stated on the reverse side of this questionnaire. Use additional numbered sheets, if necessary.)

| | | | | | | | | |
|--------------|----------|----------|-------------------------|----------|----------|--------------------------|----------|----------|
| CALMNESS () | <u>D</u> | <u>A</u> | THINKING IMPAIRED () | <u>D</u> | <u>A</u> | PERSONALITY CHANGE () | <u>D</u> | <u>A</u> |
| CURIOUS () | <u>D</u> | <u>A</u> | INVOLUNTARY ACTIONS () | <u>D</u> | <u>A</u> | RELIGIOUS EXPERIENCE () | <u>D</u> | <u>A</u> |
| ELATED () | <u>D</u> | <u>A</u> | TRANCE-LIKE STATE () | <u>D</u> | <u>A</u> | MEMORY LAPSE () | <u>D</u> | <u>A</u> |
| FEARFUL () | <u>D</u> | <u>A</u> | MENTAL TELEPATHY () | <u>D</u> | <u>A</u> | TIME LAPSE () | <u>D</u> | <u>A</u> |
| PANICKED () | <u>D</u> | <u>A</u> | DREAMS () | <u>D</u> | <u>A</u> | OTHER _____ () | <u>D</u> | <u>A</u> |

COMMENTS: _____

PHYSIOLOGICAL EFFECTS

(Use same instructions as for above)

| | | | | | | | | |
|-----------------------------|----------|----------|---------------------|----------|----------|-----------------------------|----------|----------|
| HAIR STOOD ON END () | <u>D</u> | <u>A</u> | SHOOK NERVOUSLY () | <u>D</u> | <u>A</u> | FELT ELECTRIC SHOCK () | <u>D</u> | <u>A</u> |
| HAIR BURNED () | <u>D</u> | <u>A</u> | FELT DIZZY () | <u>D</u> | <u>A</u> | BECAME PARALYZED () | <u>D</u> | <u>A</u> |
| HAIR TURNED WHITE () | <u>D</u> | <u>A</u> | FELT SLUGGISH () | <u>D</u> | <u>A</u> | BODY PERSPIRED () | <u>D</u> | <u>A</u> |
| HAIR FELL OUT () | <u>D</u> | <u>A</u> | FELT NAUSEATED () | <u>D</u> | <u>A</u> | FELT BURNING SENSATION () | <u>D</u> | <u>A</u> |
| EYES WATERED () | <u>D</u> | <u>A</u> | HAD HEADACHE () | <u>D</u> | <u>A</u> | SKIN WAS BURNED () | <u>D</u> | <u>A</u> |
| EYES SMARTED () | <u>D</u> | <u>A</u> | ORGANS VIBRATED () | <u>D</u> | <u>A</u> | EXPERIENCED SKIN RASH () | <u>D</u> | <u>A</u> |
| EYES OUT OF FOCUS () | <u>D</u> | <u>A</u> | DRY-HEAVED () | <u>D</u> | <u>A</u> | EXPERIENCED WARTS () | <u>D</u> | <u>A</u> |
| EYES BLINDED () | <u>D</u> | <u>A</u> | VOMITED () | <u>D</u> | <u>A</u> | EXPERIENCED BODY MARKS () | <u>D</u> | <u>A</u> |
| EARDRUMS VIBRATED () | <u>D</u> | <u>A</u> | PASSED URINE () | <u>D</u> | <u>A</u> | EXPERIENCED BODY WOUNDS () | <u>D</u> | <u>A</u> |
| EARS HURT () | <u>D</u> | <u>A</u> | PASSED STOOL () | <u>D</u> | <u>A</u> | SKIN PEELED OFF () | <u>D</u> | <u>A</u> |
| EARS DEAFENED () | <u>D</u> | <u>A</u> | FELT WARMER () | <u>D</u> | <u>A</u> | NECK MUSCLES ACHED () | <u>D</u> | <u>A</u> |
| NOSE IRRITATED () | <u>D</u> | <u>A</u> | FELT COLDER () | <u>D</u> | <u>A</u> | ARM MUSCLES ACHED () | <u>D</u> | <u>A</u> |
| NOSE BLED () | <u>D</u> | <u>A</u> | FELT LIGHTER () | <u>D</u> | <u>A</u> | LEG MUSCLES ACHED () | <u>D</u> | <u>A</u> |
| BLD THROUGH MOUTH () | <u>D</u> | <u>A</u> | FELT HEAVIER () | <u>D</u> | <u>A</u> | SPINAL COLUMN ACHED () | <u>D</u> | <u>A</u> |
| TOOTH FILLINGS VIBRATED () | <u>D</u> | <u>A</u> | FLOATED IN AIR () | <u>D</u> | <u>A</u> | OTHER _____ () | <u>D</u> | <u>A</u> |

RELATIONSHIP OF UFO OR ENTITY TO AFFECTED PERSON

INDIRECT: UFO MERELY OVERFLEW AREA WITH NO APPARENT INTEREST IN THE 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

INTERESTED IN PSYCHIC PHENOMENA? YES () NO () WHAT TYPE? _____

HAVE PSYCHIC ABILITIES? YES () NO () DESCRIBE _____

HAVE ABILITIES BEEN TESTED? YES () NO () BY WHOM/RESULTS? _____

MAY () MAY NOT () USE MY NAME _____ SIGNATURE OF WITNESS _____ DAY MONTH YEAR _____