

# Investigation Case Report









## Case Information

|  |     |                           |  |
|--|-----|---------------------------|--|
| Date:  | / / | Member Submitting Report: |  |
| Time:  |     | Client:                   |  |
| Type of Investigation:<br><input type="checkbox"/> Dwelling – Home, Office, etc.<br><input type="checkbox"/> Cemetery<br><input type="checkbox"/> Outdoor<br><input type="checkbox"/> Other (explain): |     | Location:                 |  |
|  |     | Team Leader:              |  |
|  |     | Team Member Present:      |  |
|  |     | Team Member Present:      |  |
|  |     | Team Member Present:      |  |
|  |     | Team Member Present:      |  |
|  |     | Team Member Present:      |  |

## Your Equipment – check all that apply.

|   |   |   |  |
|---|---|---|--|
| <input type="checkbox"/> Digital SLR Camera   | Model:  | Memory Cartridges:  |  |
| <input type="checkbox"/> Film Camera          | Model:  | Film ASA:   |  |
| <input type="checkbox"/> Tape Recorder        | Model:  | Tape Length/Type:   |  |
| <input type="checkbox"/> Digital Recorder     | Model:  | Memory:   |  |
| <input type="checkbox"/> Laptop Computer      | Model:  | Backup Hard Drive:  | USB Memory:  |
| <input type="checkbox"/> Batteries & Quantity | Size:   | AAA   | AA   |
| <input type="checkbox"/> Pen                  | <input type="checkbox"/> Paper                        | <input type="checkbox"/> Compass                                  | <input type="checkbox"/> Watch                                 |
| <input type="checkbox"/> Flashlight           | <input type="checkbox"/> Walkie-Talkies               | <input type="checkbox"/> Cellular Telephone                       | <input type="checkbox"/> Tone Generator                        |
| <input type="checkbox"/> Talcum Powder        | <input type="checkbox"/> 50 Gallon Black Plastic Bags | <input type="checkbox"/> IR Laser Thermometer                     | <input type="checkbox"/> IR Night-Vision Scope                 |
| <input type="checkbox"/> First Aid Kit        | <input type="checkbox"/> Rain Gear                    | <input type="checkbox"/> Chairs                                   | <input type="checkbox"/> Electro Magnetic Field Meter          |
| <input type="checkbox"/> Toilet Paper         | <input type="checkbox"/> Infra-Red Flashlight         | <input type="checkbox"/> Wireless Recording System w/ Microphones | <input type="checkbox"/> Thermal-Imaging IR/CCTV Camera System |
| <input type="checkbox"/> Electrical Outlets   | <input type="checkbox"/> Ultra-Violet Light           | <input type="checkbox"/> CAMcorder                                |  |
| <input type="checkbox"/> Scotch Tape          | <input type="checkbox"/> Electrical Extension Cords   | <input type="checkbox"/> 8-Cam IR D.V.R. Surveillance System      |  |
| <input type="checkbox"/> Aspirin              | <input type="checkbox"/> Tylenol                      | <input type="checkbox"/> Chemical Lights Sticks                   | <input type="checkbox"/> Matches or Lighters                   |
| <input type="checkbox"/> Candles              | <input type="checkbox"/> Personal Alarm               | <input type="checkbox"/> Food, Snacks & Water                     |  |
| <input type="checkbox"/> Thread               | <input type="checkbox"/> Strobe Lights                | <input type="checkbox"/> Clock or Watch                           |  |

## Weather Conditions

|   |   |  |
|---|---|--|
| Lunar Cycle:<br><br><input type="checkbox"/> New Moon<br><br><input type="checkbox"/> Waxing Qtr. Moon<br><br><input type="checkbox"/> Waxing Half Moon<br><br><input type="checkbox"/> Waxing 3- Qtr. Moon<br> | <input type="checkbox"/> Full Moon<br><br><input type="checkbox"/> Waning 3-Qtr. Moon<br><br><input type="checkbox"/> Waning Half Moon<br><br><input type="checkbox"/> Waning Qtr. Moon<br> | Source and Time:<br>Longitude:<br>Latitude:<br>Elevation:<br>Time: <span style="float: right;">Beginning    Ending</span><br>Temp:<br>Feels Like:<br>Dew Point:<br>Humidity:<br>Visibility:<br>Barometric Pressure:<br>Wind Speed & Direction:<br>Storm Conditions:<br><input type="checkbox"/> Clear <input type="checkbox"/> Rain <input type="checkbox"/> Fog <input type="checkbox"/> Calm<br><input type="checkbox"/> Overcast <input type="checkbox"/> Drizzle <input type="checkbox"/> Snow <input type="checkbox"/> Windy<br><input type="checkbox"/> Cloudy <input type="checkbox"/> Lightning <input type="checkbox"/> Sleety <input type="checkbox"/> Gusty |
|---|---|--|

## Experience

- Subjective Experience** – You felt or perceived something that you could not document with evidence.
- Objective Experience** – You caught evidence but did not personally feel or perceive anything.
- Real Experience** – You felt or had a subjective experience and obtained objective evidence.
- Type 1** – Both objective evidence & subjective experiences **MATCHED**.
- Type 2** – Objective evidence & subjective experiences are **DIFFERENT**.
- Type 3** – Any combination of Type 1 & 2, they both **MATCH**, but **ADDITIONAL** information was also documented.

|  |                              |                             |
|--|------------------------------|-----------------------------|
| Did you have any <b>'visual'</b> experiences?  | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| If so, did they demonstrate any intelligence with you?   | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Did you have any <b>'auditory'</b> experiences?  | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Did you have any <b>'olfactory'</b> experiences?   | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Did you have any <b>'tactile'</b> experiences?   | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| <i>(If you checked 'Yes' in any of the previous questions, please be sure to offer some detail in your report)</i> |                              |                             |

## Physical Conditions of the Location

Describe the current conditions of the location?

|   | Very Much | Somewhat | Average | Not Much | Very Little |
|---|-----------|----------|---------|----------|-------------|
| Does the overall condition of the location appear to be in good repair?               | 1         | 2        | 3       | 4        | 5           |
| Are there any of the following conditions apparent in the area you are investigating? |           |          |         |          |             |
| Drafty Windows  | 1         | 2        | 3       | 4        | 5           |
| Creaky or Unstable Floors   | 1         | 2        | 3       | 4        | 5           |
| Tapping or scrapping  | 1         | 2        | 3       | 4        | 5           |
| Noisy Pipes   | 1         | 2        | 3       | 4        | 5           |
| In the area considered haunted by the eyewitnesses did you notice?                    |           |          |         |          |             |
| Sudden changes in Temperature   | 1         | 2        | 3       | 4        | 5           |
| Changes in the Weather  | 1         | 2        | 3       | 4        | 5           |
| Any Apparitions   | 1         | 2        | 3       | 4        | 5           |
| Sensation of Being Watched  | 1         | 2        | 3       | 4        | 5           |
| Sudden Mood Changes   | 1         | 2        | 3       | 4        | 5           |
| Discarnate Voices   | 1         | 2        | 3       | 4        | 5           |
| Electrical Problems like flickering lights  | 1         | 2        | 3       | 4        | 5           |
| Disappearing Objects  | 1         | 2        | 3       | 4        | 5           |
| Telekinesis   | 1         | 2        | 3       | 4        | 5           |

## Observations

Be as precise and factual as possible, trying not to use conjecture (stick to the evidence and don't make assumptions about the results). Don't forget to specify what you did & what equipment you may have used to form your hypothesis. And by all means, please tell us how you personally felt before, during, and after any subjective/objective experiences you may have had, how you felt the investigation went as a whole in your conclusion.

Hint: Try to describe the investigative processes you followed and describe any evidence you may have documented and why it was important. Please try not to get too wordy and yet still describe what needs to be said.

|  |
|--|
| <b>Describe the room – location of furniture &amp; vigil team (paint the reader a picture, we weren't there):</b>      |
| <br><br><br><br><br>   |
| <b>Describe the atmosphere of the room &amp; location of doors, windows, lighting, etc:</b>                            |
| <br><br><br><br><br>   |
| <b>Any additional information that could be important regarding the vigil(s) or specifics about the investigation:</b> |
| <br><br><br><br><br>   |

### Vigil 1 - Location

| Time | Description                 |
|------|-----------------------------|
|      | <i>Began Investigation.</i> |
|      |                             |
|      |                             |
|      |                             |
|      |                             |
|      |                             |

### Vigil 2 - Location

| Time | Description |
|------|-------------|
|      |             |
|      |             |
|      |             |
|      |             |
|      |             |
|      |             |

### Vigil 3 - Location

| Time | Description                 |
|------|-----------------------------|
|      |                             |
|      |                             |
|      |                             |
|      |                             |
|      |                             |
|      |                             |
|      | <i>Ended Investigation.</i> |

### Evidence

**IMPORTANT - Be sure to include ALL evidence from the investigation to your Team Leader WITHIN 72 HOURS.**

|   |  |
|---|--|
| Electronic Voice Phenomena – EVP <input type="checkbox"/> Yes <input type="checkbox"/> No | IR Photography <input type="checkbox"/> Yes <input type="checkbox"/> No                |
| Digital Photographs <input type="checkbox"/> Yes <input type="checkbox"/> No              | IR Video <input type="checkbox"/> Yes <input type="checkbox"/> No                      |
| Film Photographs <input type="checkbox"/> Yes <input type="checkbox"/> No                 | Recorded Thermal Video <input type="checkbox"/> Yes <input type="checkbox"/> No        |
| Video Recording <input type="checkbox"/> Yes <input type="checkbox"/> No                  | Recorded Thermal Photographs <input type="checkbox"/> Yes <input type="checkbox"/> No  |
| Temperature Changes <input type="checkbox"/> Yes <input type="checkbox"/> No              | Other – Explain <input type="checkbox"/> Yes <input type="checkbox"/> No               |
| EMF Readings <input type="checkbox"/> Yes <input type="checkbox"/> No                     | Any signs found of tampering? <input type="checkbox"/> Yes <input type="checkbox"/> No |

If not listed, what other type of evidence did you gather?

### Conclusion

How did you feel about the investigation? And please offer an explanation why you feel this way, if necessary. (Use another sheet of paper if necessary.)



*In the Shadows*  
PARANORMAL PROJECT