S.P.I.R.I.T.S. of New England
CLIENT INVESTIGATION FORM

DATE:	

NAME:					
ADDRESS:					
CITY:		STATE:		ZIP CODE:	
PHONE NO.:		CELL NO.:			
EMAIL:					

OWNERS/OCCUPANTS NAMES (INCLUDING YOURSELF)	GENDER (M / F)	RELATIONSHIP	DATE OF BIRTH / AGE

STRUCTURAL INFORMATION

BUILDING TYPE: (CHECK ONE)	Detached Residence	☐	Duplex	☐	Condo	☐	Apartment	☐	Other	☐

DO YOU OWN OR RENT?							
NO. OF BEDROOMS:		BATHROOMS:		SQUARE FEET:		LOT SIZE (SQ. FT.):	

ADDITIONAL ROOMS & OTHER INFORMATION:

HOW MANY YEARS AND/OR MONTHS HAVE YOU LIVED AT THE LOCATION?

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ANY KNOWN HISTORY OF LOCATION? (STRUCTURAL CHANGES, PREVIOUS OCCUPANTS, OTHER PARANORMAL ACTIVITY, ETC.)

HAVE ANY OTHER BUILDINGS BEEN CONSTRUCTED ON THE SITE PREVIOUS TO THE CURRENT ONE? IF YES, EXPLAIN:

IS THERE ANY KNOWN HISTORY OF THE SURROUNDING AREA? (OLD SCHOOLS, GRAVE SITES, OLD COURTS, OLD CHURCHES, ETC.)

ARE THERE ANY ACCOUNTS OF PARANORMAL ACTIVITY AT YOUR PREVIOUS RESIDENCE?

WERE ANY TRAGEDIES OR DEATHS ASSOCIATED WITH THE IMMEDIATE AREA OR NEIGHBORHOOD? IF YES, EXPLAIN:

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IS THERE ANY DOCUMENTATION OF PREVIOUS PARANORMAL ACTIVITY? (NEWSPAPER CLIPPINGS, ETC.)

RELIGIOUS & MEDICAL BACKGROUND

WHAT, IF ANY, IS YOUR RELIGIOUS BACKGROUND? (BOTH FAMILY AND YOUR PRESENT RELIGIOUS STATUS)

ANY HISTORY OF ALCOHOL OR DRUG ABUSE?

ANY HISTORY OF MENTAL ILLNESS? IF YES, EXPLAIN:

ANY HISTORY OF SERIOUS TRAUMA? (NEAR DEATH, RAPE, ETC.)

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LIST ALL MEDICATIONS AND PRESCRIPTION ITEMS USED IN THE PAST THREE YEARS. INCLUDE ALL PRESCRIPTION DRUGS, OVER-THE-COUNTER DRUGS, PRESCRIPTION EYE GLASSES, CONTACT LENSES, ETC. PLEASE MAKE A SEPARATE LIST FOR EACH OCCUPANT.

HAVE ANYONE'S PRESCRIPTIONS CHANGED RECENTLY?

ANY OTHER FAMILY HISTORY YOU THINK IS IMPORTANT?

WHEN DID THE CURRENT DISTURBANCES BEGIN AND WHAT HAPPENED FIRST?

WHAT DID YOU THINK OF THESE DISTURBANCES?

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HAVE YOU LOOKED FOR ORDINARY, NORMAL EXPLANATIONS? WHAT MAKES YOU THINK IT'S PARANORMAL?

WHEN DID THE MOST RECENT INCIDENT OCCUR AND WHAT HAPPENED?

HAVE THE DISTURBANCES BEEN INCREASING IN FREQUENCY AND/OR SEVERITY SINCE THEY FIRST BEGAN?

ARE EVENTS MORE FREQUENT AT CERTAIN TIMES DURING THE 24 HOURS OF THE DAY THAN AT OTHERS? IF YES, WHAT TIMES?

IS THERE A PATTERN OF ANY KIND TO THESE DISTURBANCES THAT YOU'VE NOTICED (IE: WHEN THE EVENTS OCCURRED, WHAT SORTS OF OBJECTS WERE AFFECTED, WHAT LOCATIONS WERE INVOLVED, WHO WAS AROUND AT THE TIME, ETC.)?

IS ACTIVITY MORE FREQUENT IN CERTAIN PLACES (FOR EXAMPLE, IN CERTAIN ROOMS OF THE HOUSE) THAN IN OTHERS? IF YES, WHERE?

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DO THE OCCURRENCES HAPPEN MORE FREQUENTLY IN THE PRESENCE OR VICINITY OF CERTAIN PERSONS THAN THEY DO WITH OTHERS? IF YES, STATE WHICH PEOPLE. ALSO, DO THE EVENTS TAKE PLACE WHEN THEY ARE NOT IN THE AREA?

HAVE THERE BEEN ANY WITNESSES FROM OUTSIDE THE HOUSEHOLD? WHAT DID THEY EXPERIENCE, AS FAR AS YOU KNOW?

HAS ANYONE EVER SEEN AN OBJECT START TO MOVE WHEN NO ONE WAS NEAR IT? IF YES, DESCRIBE ALL SUCH OCCURRENCES.

IF THERE HAVE BEEN UNEXPLAINED MOVEMENTS OF OBJECTS, WAS THERE ANYTHING STRANGE ABOUT THE MANNER IN WHICH THE OBJECTS MOVED OR STOPPED? (E.G.: OBJECTS THAT MOVE AROUND CORNERS, OR HIT WITH UNUSUALLY GREAT FORCE, ETC.)

HAVE YOU OR ANYONE IN THE RESIDENCE EVER USED OR EXPERIMENTED WITH OUIJA BOARDS, SÉANCES, ETC.?

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HAVE YOU OR ANYONE IN THE RESIDENCE EVER USED OR EXPERIMENTED WITH BLACK MAGIC OR USED ANY TYPE OF WITCHCRAFT FOR PERSONAL GAIN? (E.G.: MONEY, LOVE, FAME, ETC.) IF YES, PLEASE EXPLAIN:

HOW WOULD YOU LIKE TO BE HELPED?

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HAVE ANY OF THE OCCUPANTS ENCOUNTERED ANY OF THE FOLLOWING? (EXPLAIN ALL THAT APPLY)

1. **Voices:** ☐

2. **Smells/Odors:** ☐

3. **Shadows:** ☐

4. **Orbs:** ☐

5. **Smoky Forms:** ☐

6. **Strong Random Thoughts:** ☐

7. **Strong Feelings/Emotions:** ☐

8. **Cold Spots:** ☐

9. **Hot Spots:** ☐

10. **Recent Death of Loved One:** ☐

11. **Recent Anniversary of Loved One's Death, Birthday, Anniversary, etc.:** ☐

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12. Sounds (Walking, Running, Knocking, etc.): ☐

13. Door(s) Opening/Closing: ☐

14. Mood Changes, Especially in One Room: ☐

15. Conversations With Spirits: ☐

16. Conversations Between Spirits: ☐

17. Disappearing Objects: ☐

18. Objects Moving: ☐

19. Puberty of Family Member or Emotional Stress of Adolescents in Area: ☐

20. Renovations to Location: ☐

21. Electrical Disturbances (Frequent Light Bulb Burnouts, etc.): ☐

22. Problems with Appliances (TV, Radio, Stereo, Computers, Clocks, Microwave, etc.): ☐

23. Headaches or Dizziness: ☐

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24. Feeling of Being Touched: ☐

25. Physical Harm (Scratches, Cuts, Bites, etc.): ☐

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ANY ADDITIONAL INFORMATION, NOTES OR QUESTIONS