

Fill it out. Drop it off.

(Fill out the information and leave form along with vehicle keys in the orange drop box located on the side of the blue building)

Name: _____ Phone: _____ Cell: _____

Address: _____ City: _____ State: _____ Zip: _____

Vehicle Year: _____ Make: _____ Model: _____

Services

- Oil & Filter Change Tires/ Rotation Transmission Service Brake Inspection
 Front End Alignment Check Engine Light Running rough Starting Problem
 Other _____

Symptoms: (Check all that apply)

- Hard to start Idle speed is unsteady Continues to run after turned off
 Will not start Idle speed is too high Backfires
 Starts but stalls Hesitates or stalls on acceleration Speed changes for no reason
 Pings or knocks Stalls on deceleration or quick stop Poor gas mileage(____MPG)
 Noise when braking Clunk/noise when turning Tires worn

Other _____

The Symptoms Occur During: (Check all that apply)

- Accelerating Decelerating Cruising Braking Turning At _____MPH

The Symptoms Occur When Engine Is: (Check all that apply)

- Cold Warming Up Normal Hot At all temperatures

The Symptoms Occur:

- Rarely Sometimes All the time

The Symptoms Started:

- Suddenly Gradually At _____
Mileage

Other: _____

