Fill it out. Drop it off.

Name:_____ Phone:_____ Alternate Phone: _____

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

Email Address: _____

Vehicle Year:_____ Make:_____ Model: _____

SERVICES

☐ Oil & Filter Change ☐ Tire Rotation ☐ Transmission Service ☐ Brake Inspection ☐ Front End Alignment

☐ 30,000 Mile Maintenance ☐ 60,000 Mile Maintenance ☐ 90,000 Mile Maintenance ☐ Replace Wipers

SYMPTOMS: (Check all that apply)

☐ Hard to start
☐ Will not start
☐ Starts but stalls
☐ Pings or knocks
☐ Idle speed is unsteady
☐ Idle speed is too high
☐ Hesitates or stalls on acceleration
☐ Stalls on deceleration or quick stop
☐ Continues to run after turned off
☐ Backfires
☐ Speed changes for no reason
☐ Poor gas mileage (_____MPG)

THE SYMPTOMS OCCUR DURING: (Check all that apply)

☐ Accelerating ☐ Decelerating ☐ Cruising ☐ Braking ☐ At a speed of_____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:_____

_____

_____

_____