

Bob & Jeff's Symptom Form

Name _____

Vehicle _____

Remote Starter? Yes No

1. What is the symptom to be corrected?

2. When did this first happen?

Today _____ Week _____ Month Other _____

3. How often is it happening?

All the Time _____ Week's _____ Month Other _____

4. Does this happen at certain speeds?

No Accelerating Idle Slowing Stopping Stopped
Other _____

5. Are there any warning lights, or gauges read incorrectly?

No Yes When _____

6. Does this happen when car is cold or warmed up?

No Cold Warm Hot After _____ Min Other _____

7. Is it affected by weather?

No Hot Cold Damp
Other _____

8. Are there any new parts or repairs done recently?

No Yes When _____

9. Happened before, someone worked on for this before?

No Yes When _____

10. Any other ways it does not run, drive or work correctly ?

(Ask the question until they answer NO!) Yes No

11. Any other repairs need scheduled while vehicle is in shop?

NO LOF BRAKES FF C-FLUSH T-FLUSH EXHAUST
Other: _____

12. When do you need the car back by?

Same Day Next Day Other _____ Time: _____ AM PM

13. Who do we contact quickly?

_____ Phone: _____ Cell: _____

14. What do you expect when your car is picked up? (Confirm what you heard)

Scheduled: _____