Customer Service Evaluation Sheet
In Order for US to SERVE YOU Better!

(Name)________________________________ (Date) __________________________
(Year, Make, Model) _________________________ (Color)_____________________
(License #)_____________ (Mileage) ___________ Transmission (MT) ___ (AT) ___
Best # to call___________________________ Best Time to call __________________

Service Schedule Work:

Scheduled Maintenance Service _______________ **Other**______________ **Mileage** _______

Symptoms:

☐ Unable to Start	☐ Engine Turns but it will not start ☐ Engine Does Not Turn Over ☐ Other ________________
☐ Hard Starting	☐ Engine Turns Over Too Long ☐ Engine Turns Over Slowly ☐ Other ________________
☐ Poor Idling	☐ Rough Idle ☐ Incorrect Idle (Too High / Too Low) ☐ Unstable Idling ☐ Other ________________
☐ Poor Drivability	☐ Surging ☐ Backfire ☐ Hesitation ☐ Knocking ☐ No Power ☐ Other ________________
☐ Stalling	☐ Soon After Starting ☐ After Accelerator Pedal is Pressed ☐ With A/C On ☐ Shifting from N to D ☐ Other____________
☐ Engine Light On	☐ Red ☐ Always On ☐ Sometimes On ☐ Flashing ☐ Orange ☐ Other ________________
☐ Other	☐ Other ________________________________ ________________________________

Conditions:

☐ Problem Frequency	☐ Constant ☐ Sometimes ________________________ ☐ Other ________________________________
☐ Conditions	☐ When Engine Cold ☐ When Engine Hot ☐ When Raining ☐ First Start in AM ☐ Other ________________
☐ Place	☐ While Driving in Traffic ☐ While Driving on Highway ☐ While Driving Up Hills ☐ Other ________________
☐ History	☐ Car is Due for Service ☐ Problem Occurs Since Last Service ☐ Vehicle was Serviced Elsewhere ☐ Other ____________

Were ANY services performed at home or at another facility? Yes / No
What:____

_______________________________________ ____________________
(Signature) **(Date)**

Thank you for taking the time to answer these questions!