SUSPENSION QUESTIONNAIRE

Please take a few minutes to complete this form to the best of your ability so we may serve you better. Bring it with you to your scheduled appointment or place it in the drop box envelope with your keys for a night drop off. Thank you.

Customer Name: _____ Radio code: _____

Address:_____ City:_____ State:____ ZIP: _____

Phone No: _____ ☐ Call ☐ Text Phone No: _____ ☐ Call ☐ Text

Vehicle Year, Make & Model:_____ Mileage(optional):_____

Does your vehicle have wheel locks? ☐ Yes ☐ No If so, Key location: _____

***Please check all applicable boxes and fully describe the condition that applies to your vehicle.*

Does it appear that the tires are cupped or wearing unevenly? ☐ Yes ☐ No

Does the vehicle sway on turns? ☐ Yes ☐ No

Does the vehicle lean on turns? ☐ Yes ☐ No

Does the vehicle drift left while driving? ☐ Yes ☐ No

Does the vehicle drift right while driving? ☐ Yes ☐ No

Does the vehicle "nose dive" when you apply the brakes? ☐ Yes ☐ No
*This condition can affect your ability to stop the vehicle quickly, increasing stopping time by up to 20%.

Does the vehicle "bottom out" when you have multiple passengers in the back seat? ☐ Yes ☐ No

Is there excessive bouncing when you ride over bumps? ☐ Yes ☐ No

Do you experience a harsh, bumpy or shaky ride? ☐ Yes ☐ No

Does the vehicle feel unstable at high speeds? ☐ Yes ☐ No

Is the steering wheel off center?

Do you feel steering wheel vibration?

Do you feel your car is being blown around more than normal during windy conditions on the Highway? ☐ Yes ☐ No

Optional - If visible, do you see oil leaking from the shocks or struts? ☐ Yes ☐ No

Additional Comments: _____

_____

_____ _____

Signature Date