



DIAGNOSTIC FORM FOR:

# NOISE, VIBRATION OR HARSHNESS

Customer Name: \_\_\_\_\_

Date: \_\_\_\_\_ RO#: \_\_\_\_\_

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

## 1. THIS IS THE PROBLEM

- Vehicle is making a noise  
The noise sounds like:
- |  |                                 |
|--|---------------------------------|
| <input type="checkbox"/> Bump                  | <input type="checkbox"/> Clunk  |
| <input type="checkbox"/> Rattle                | <input type="checkbox"/> Squeak |
| <input type="checkbox"/> Boom                  | <input type="checkbox"/> Drone  |
| <input type="checkbox"/> Whine                 | <input type="checkbox"/> Growl  |
| <input type="checkbox"/> Other, describe _____ |                                 |

- Vehicle has a vibration  
The vibration might sound like:
- |  |                                     |
|--|-------------------------------------|
| <input type="checkbox"/> Buzz                  | <input type="checkbox"/> Rattle     |
| <input type="checkbox"/> Growl                 | <input type="checkbox"/> Resonating |
| <input type="checkbox"/> Other, describe _____ |                                     |

- Vehicle harshness  
The vehicle is:
- |                                |   |
|--------------------------------|---|
| <input type="checkbox"/> Buzz  | <input type="checkbox"/> Hum                    |
| <input type="checkbox"/> Growl | <input type="checkbox"/> Boom                   |
| <input type="checkbox"/> Drone | <input type="checkbox"/> Other, please describe |

- Spend 1 hour diagnosing the problem, and make sure vehicle is safe.
- Spend up to 3 hours diagnosing the problem.

## 2. IT OCCURS AS FOLLOWS

- Heard or felt from \_\_\_\_\_ part of the car
- |  |   |                               |
|--|---|-------------------------------|
| <input type="checkbox"/> Front         | <input type="checkbox"/> Right          | <input type="checkbox"/> Left |
| <input type="checkbox"/> Rear          | <input type="checkbox"/> Right          | <input type="checkbox"/> Left |
| <input type="checkbox"/> Inside of car | <input type="checkbox"/> Outside of car |                               |
| <input type="checkbox"/> Under the car |   |                               |

- It occurs at:
- |  |   |
|--|---|
| <input type="checkbox"/> Idle                | <input type="checkbox"/> Light Acceleration |
| <input type="checkbox"/> Medium Acceleration | <input type="checkbox"/> Heavy Acceleration |
| _____ MPH                                    |   |

- It happens:
- |   |
|---|
| <input type="checkbox"/> All the time                             |
| <input type="checkbox"/> Once a day                               |
| <input type="checkbox"/> Once a week                              |
| <input type="checkbox"/> Once a month                             |
| <input type="checkbox"/> The last time the problem occurred _____ |
| <input type="checkbox"/> Other, please describe _____             |

- The engine was:
- |                               |                              |   |
|-------------------------------|------------------------------|---|
| <input type="checkbox"/> Cold | <input type="checkbox"/> Hot | <input type="checkbox"/> Normal operating temperature |
|-------------------------------|------------------------------|---|

- The outside temperature was:
- |  |                                  |
|--|----------------------------------|
| <input type="checkbox"/> Cold                  | <input type="checkbox"/> Sunny   |
| <input type="checkbox"/> Warm                  | <input type="checkbox"/> Dry     |
| <input type="checkbox"/> Hot                   | <input type="checkbox"/> Raining |
| <input type="checkbox"/> Other, describe _____ |                                  |

- |                               |                              |                             |
|-------------------------------|------------------------------|-----------------------------|
| AC on?                        | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Towing a trailer?             | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Windows down?                 | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Other _____                   |                              |                             |
| Is the problem getting worse? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

Additional Information: