

# BRAKE SYMPTOM SHEET

Check All That Apply

---

## SYMPTOM

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Pulls right when braking                 | <input type="checkbox"/> Brake light on                 | <input type="checkbox"/> Pedal goes to floor       |
| <input type="checkbox"/> Pulls left when braking                  | <input type="checkbox"/> Abs light on                   | <input type="checkbox"/> Leaking brake fluid       |
| <input type="checkbox"/> Grinding noise                           | <input type="checkbox"/> Soft pedal                     | <input type="checkbox"/> Traction control light on |
| <input type="checkbox"/> No brakes at all                         | <input type="checkbox"/> Hard Pedal                     | <input type="checkbox"/> Squealing noise           |
| <input type="checkbox"/> Pulsating in seat when braking           | <input type="checkbox"/> Not as good as they used to be |  |
| <input type="checkbox"/> Pulsating in steering wheel when braking |   |  |
| <input type="checkbox"/> Other: _____                             |   |  |

## WHEN DOES IT OCCUR?

- |                                       |                                       |  |
|---------------------------------------|---------------------------------------|--|
| <input type="checkbox"/> All the time | <input type="checkbox"/> Braking      | <input type="checkbox"/> Letting go of brake pedal |
| <input type="checkbox"/> Intermittent | <input type="checkbox"/> Accelerating | <input type="checkbox"/> Hot outside               |
| <input type="checkbox"/> Turning      | <input type="checkbox"/> Decelerating | <input type="checkbox"/> Cold outside              |
| <input type="checkbox"/> Other: _____ |                                       |  |

## HOW LONG HAS IT BEEN OCCURING?

- |                                       |                                     |                                      |                                    |
|---------------------------------------|-------------------------------------|--------------------------------------|------------------------------------|
| <input type="checkbox"/> Just started | <input type="checkbox"/> Few weeks  | <input type="checkbox"/> Few days    | <input type="checkbox"/> Few hours |
| <input type="checkbox"/> Not sure     | <input type="checkbox"/> Few months | <input type="checkbox"/> A long time | <input type="checkbox"/> Gradually |
| <input type="checkbox"/> Other: _____ |                                     |                                      |                                    |

EXPLAIN IN MORE DETAIL (if needed): \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

