



Cornell University
Cooperative Extension
Rockland County

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 www.rocklandcce.org

House Plant Diagnosis \$7.00

The quality of your specimen is critical for receiving an accurate diagnosis. Please submit a sample that includes a progression of the problem on vegetative growth, such as a branch/stem with healthy to unhealthy foliage. Dead (plant, branch, fruit/vegetable or leaf) specimens are difficult and sometimes impossible to identify or diagnose.

Please Print

Name _____
 Address _____
 City/State/Zip _____
 Phone _____

Date Received _____
Date Finished _____
Called _____
Sent F.S. <input type="checkbox"/>

Date Collected _____

Name of Plant _____ Variety _____ Age of Plant _____ Size _____

Pot Size:	<input type="checkbox"/> 4"	<input type="checkbox"/> 6"	<input type="checkbox"/> 8"	<input type="checkbox"/> 10"	<input type="checkbox"/> 12" or more	<input type="checkbox"/> Flat or Dish	<input type="checkbox"/> Bonsai	<input type="checkbox"/> Other _____	
Drainage Holes	<input type="checkbox"/> Yes	<input type="checkbox"/> No							
Soil Type	<input type="checkbox"/> Compost Based		<input type="checkbox"/> Soil-less		<input type="checkbox"/> Sandy		<input type="checkbox"/> Other _____		
Watering Frequency	<input type="checkbox"/> <Once weekly		<input type="checkbox"/> Once weekly		<input type="checkbox"/> > Once weekly				
Humidity:	<input type="checkbox"/> Low		<input type="checkbox"/> Medium		<input type="checkbox"/> High				

Lighting: # of hours _____	<input type="checkbox"/> Direct Sun	<input type="checkbox"/> Artificial Light	<input type="checkbox"/> Bright, Indirect	<input type="checkbox"/> Low-light
Plant (window) Faces	<input type="checkbox"/> North	<input type="checkbox"/> South	<input type="checkbox"/> East	<input type="checkbox"/> West
Distance from window _____			Room Temperature _____	
Location	<input type="checkbox"/> Near Door	<input type="checkbox"/> Heater	<input type="checkbox"/> Other _____	
	<input type="checkbox"/> Open Window	<input type="checkbox"/> AC		

Chemical Treatment	<input type="checkbox"/> None	<input type="checkbox"/> Fertilizer	<input type="checkbox"/> Fungicide	When Applied
	<input type="checkbox"/> Biostimulant	<input type="checkbox"/> Insecticide	<input type="checkbox"/> Herbicide	_____
Pattern of Problem	<input type="checkbox"/> Single Plant	<input type="checkbox"/> Upper Portion	<input type="checkbox"/> New Growth	<input type="checkbox"/> One Side Only
	<input type="checkbox"/> Random Plants	<input type="checkbox"/> Lower Portion	<input type="checkbox"/> Older Growth	<input type="checkbox"/> Other _____
	<input type="checkbox"/> All Plants	<input type="checkbox"/> Entire Plant		
Parts Affected	<input type="checkbox"/> Leaves	<input type="checkbox"/> Buds	<input type="checkbox"/> Fruit	<input type="checkbox"/> Roots
	<input type="checkbox"/> Stems	<input type="checkbox"/> Flowers		
Symptoms	<input type="checkbox"/> Leaf Spot	<input type="checkbox"/> Burn or Scorch	<input type="checkbox"/> Stunting	<input type="checkbox"/> Rot/Fruit Decay
	<input type="checkbox"/> Leaf Drop	<input type="checkbox"/> Wilting	<input type="checkbox"/> Distortion	Other _____
	<input type="checkbox"/> Yellowing	<input type="checkbox"/> Dieback	<input type="checkbox"/> Galls or Swelling	

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