



**Cornell University**  
**Cooperative Extension**  
**Rockland County**

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**Woody Plant Diagnosis \$7.00**  
**(Trees and Shrubs)**

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 branch/stem with healthy to unhealthy foliage. Dead (plant, branch, fruit/vegetable or leaf) specimens are difficult and sometimes impossible to identify or diagnose.

<b>Please Print</b>	Date Collected _____	<b>Office Use</b>
Name _____		Date Received _____
Address _____		Date Finished _____
City _____ Zip _____		Called _____
Phone # _____		Sent F.S <input type="checkbox"/>

**Name of Plant:** Common \_\_\_\_\_ Scientific \_\_\_\_\_

**Age of Plant(s)** \_\_\_\_\_ **Size of Plant(s)** \_\_\_\_\_ **% Damage** \_\_\_\_\_ **Date Problem Noticed** \_\_\_\_\_

**Onset of Symptoms:** Overnight \_\_\_\_\_ Days \_\_\_\_\_ Weeks \_\_\_\_\_ Months or more \_\_\_\_\_

<b>Site Conditions:</b>	<input type="checkbox"/> Foundation	<input type="checkbox"/> Container	<input type="checkbox"/> Mulched Bed	
<b>Location of Plant</b>	<input type="checkbox"/> Front Yard	<input type="checkbox"/> Berm	Depth of Mulch _____	
	<input type="checkbox"/> Back or Side	<input type="checkbox"/> Mixed Planting	Type of Mulch _____	Feet away from Street, Drive, Walk or Pool _____
	<input type="checkbox"/> Lawn	Other _____		
<b>Exposure</b>	<input type="checkbox"/> Sunny (6+ hrs)	<input type="checkbox"/> Partial Shade	<input type="checkbox"/> Full Shade	
<b>Site Faces</b>	<input type="checkbox"/> North	<input type="checkbox"/> South	<input type="checkbox"/> East	<input type="checkbox"/> West
<b>Terrain</b>	<input type="checkbox"/> Low or Wet	<input type="checkbox"/> High or Dry	<input type="checkbox"/> Flat	<input type="checkbox"/> Sloped
<b>Soil Type</b>	<input type="checkbox"/> Clay	<input type="checkbox"/> Loam	<input type="checkbox"/> Sand	<input type="checkbox"/> Potting Soil
<b>Drainage</b>	<input type="checkbox"/> Slow (standing water more than one day)	<input type="checkbox"/> Medium (no standing water, but soil stays moist)	<input type="checkbox"/> Fast (runs off quickly)	<input type="checkbox"/> Heavy Compaction
<b>Watering Frequency</b>	<input type="checkbox"/> <Once weekly	<b>Delivery Method</b>	<input type="checkbox"/> Hose/Sprinkler	Duration _____
<input type="checkbox"/> Occasional/Rarely	<input type="checkbox"/> Once weekly		<input type="checkbox"/> Drip	
<input type="checkbox"/> Never	<input type="checkbox"/> > Once weekly		<input type="checkbox"/> Auto Irrigation	
<b>Chemical Treatment</b>	<input type="checkbox"/> None	<input type="checkbox"/> Fertilizer	<input type="checkbox"/> Fungicide	What/When Applied _____
	<input type="checkbox"/> Bio-stimulant	<input type="checkbox"/> Insecticide	<input type="checkbox"/> Herbicide	
<b>Unusual Conditions</b>	<input type="checkbox"/> Construction	<input type="checkbox"/> Flooding	<input type="checkbox"/> Injuries	Other _____

<b>Pattern of Problem</b>	<input type="checkbox"/> Single Plant	<input type="checkbox"/> Upper Portion	<input type="checkbox"/> Branch Tips	<input type="checkbox"/> One Side Only
	<input type="checkbox"/> Random Plants	<input type="checkbox"/> Lower Portion	<input type="checkbox"/> Inside Portion	<input type="checkbox"/> Other _____
	<input type="checkbox"/> Entire Planting	<input type="checkbox"/> Entire Plant		
<b>Parts Affected</b>	<input type="checkbox"/> Leaves/Needles	<input type="checkbox"/> Wounds on Main Trunk or Branches	<input type="checkbox"/> Buds	<input type="checkbox"/> Roots
	<input type="checkbox"/> Twigs/Branches		<input type="checkbox"/> Flowers	<input type="checkbox"/> Root Flare
	<input type="checkbox"/> Stems/Trunk		<input type="checkbox"/> Fruit	
<b>Symptoms</b>	<input type="checkbox"/> Leaf Spot	<input type="checkbox"/> Burn or Scorch	<input type="checkbox"/> Stunting	<input type="checkbox"/> Canker
	<input type="checkbox"/> Leaf Drop	<input type="checkbox"/> Wilting	<input type="checkbox"/> Distortion	<input type="checkbox"/> Rot/Fruit Decay
	<input type="checkbox"/> Yellowing	<input type="checkbox"/> Dieback	<input type="checkbox"/> Galls or Swelling	Other _____

**Office Use Only:**