



Date:	Distribution of Problem: Number plants affected:
Name: <input type="checkbox"/> Commercial <input type="checkbox"/> Homeowner	or Percent: For tree fruit: <input type="checkbox"/> A few branches <input type="checkbox"/> Whole tree
Mailing Address: City: _____ State: _____ Zip Code: _____	When was the problem first observed? Is the problem getting worse? <input type="checkbox"/> Yes <input type="checkbox"/> No
Phone Number: Primary _____ Other _____ Other _____	How often do you water? (VERY IMPORTANT!) (By the day- check all that apply) <input type="checkbox"/> Monday <input type="checkbox"/> Tuesday <input type="checkbox"/> Wednesday <input type="checkbox"/> Thursday <input type="checkbox"/> Friday <input type="checkbox"/> Saturday <input type="checkbox"/> Sunday <input type="checkbox"/> By intervals _____ (every 3 rd day, etc.)
Email Address:	How long do you water?
Plant Species (Scientific or common name):	Describe your watering method <input type="checkbox"/> Pop up rotor sprinklers <input type="checkbox"/> Hose-end sprinkler <input type="checkbox"/> Pop up stationary sprinklers <input type="checkbox"/> Flood irrigate <input type="checkbox"/> Drip (gph _____ # emitters _____) <input type="checkbox"/> By hand
Age of Plant(s):	Pesticides & Fertilizer (VERY IMPORTANT): Name of Product: _____ Rate and date applied: _____
Growing Situation <input type="checkbox"/> Residential lawn <input type="checkbox"/> Orchard <input type="checkbox"/> Garden <input type="checkbox"/> Containers	Have weed killers been used within 50' of the plant in the last 5 years? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, what kind? _____
Plant Parts Affected: <input type="checkbox"/> Stems <input type="checkbox"/> Roots <input type="checkbox"/> Leaves <input type="checkbox"/> Blossoms <input type="checkbox"/> Twigs/Branches <input type="checkbox"/> Trunk <input type="checkbox"/> Fruit	Has any soil been added around the tree/shrub since it was planted? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, how many inches of soil were added? ____ How long ago was the soil added? _____
Symptoms: <input type="checkbox"/> Wilting <input type="checkbox"/> Yellowing <input type="checkbox"/> Dieback <input type="checkbox"/> Leaf Drop <input type="checkbox"/> Skeletonizing <input type="checkbox"/> Marginal Burn <input type="checkbox"/> Borer Holes <input type="checkbox"/> Leaf Spots/Blight <input type="checkbox"/> Galls <input type="checkbox"/> Fruit damage/spots/blemishes <input type="checkbox"/> Other	Describe symptom development

FOR OFFICE USE ONLY:

Diagnostician	
Diagnostic Date	
Identification	
Control	
Comments	
Date Replied	
Person Contacted	<hr/> <input type="checkbox"/> Phone <input type="checkbox"/> Email <input type="checkbox"/> Mail <input type="checkbox"/> In Person <input type="checkbox"/> Sent to Logan
Name of person who contacted them	

Statistical Reporting (Optional*)

Gender:

- Male Female

Ethnicity:

- Caucasian Hispanic American Indian African American
 Pacific Islander Other:

*As part of the United States Department of Agriculture, USU Extension must demonstrate that it does not discriminate in the dissemination of its programs.