



Number:		Date Received:		Date Serviced:		Name of MG:																									
Client Name:				Daytime Phone:		County:																									
Mailing Address:				City:		State/Zip:																									
E-Mail Address:				Sample Provided <input type="checkbox"/> Yes <input type="checkbox"/> No		Client Contacted MG via: <input type="checkbox"/> Personal visit to office <input type="checkbox"/> Phone call <input type="checkbox"/> _____																									
Type of plant: <input type="checkbox"/> Broadleaf Tree <input type="checkbox"/> Shrub/vine <input type="checkbox"/> Flower <input type="checkbox"/> Vegetable <input type="checkbox"/> Herb <input type="checkbox"/> Fruit Tree <input type="checkbox"/> House Plant <input type="checkbox"/> Other _____																															
Name of plant: _____																															
Age of plant:			Recent Transplant?			Approximate size:																									
How was plant received: <input type="checkbox"/> Balled and burlapped <input type="checkbox"/> Plastic pot <input type="checkbox"/> Bare root <input type="checkbox"/> Peat/paper pot			Planting Preparation: <input type="checkbox"/> Pot/burlap removed from root ball <input type="checkbox"/> Peat/manure/compost added to back fill <input type="checkbox"/> Fertilizer applied at/after planting <input type="checkbox"/> Winter Protection			<input type="checkbox"/> Planted by landscaper <input type="checkbox"/> Planted by previous owner <input type="checkbox"/> Planted by Client <input type="checkbox"/> Other: _____																									
Planting area mulched with: <input type="checkbox"/> No mulch <input type="checkbox"/> Bark mulch <input type="checkbox"/> Landscape Cloth <input type="checkbox"/> Rock/inorganic <input type="checkbox"/> Other _____																															
Damage: Plant Parts/Pattern of Progression: <input type="checkbox"/> Leaves/Flowers <input type="checkbox"/> Started at bottom & moved up <input type="checkbox"/> Started at the top and moved down <input type="checkbox"/> Entire plant affected <input type="checkbox"/> Structure/Fruit <input type="checkbox"/> Only on the tips of branches <input type="checkbox"/> Only on inside branches <input type="checkbox"/> Only on one side [N S E W]																															
Expanse of Damaged Area: <input type="checkbox"/> Scattered plants <input type="checkbox"/> Various plants in a group <input type="checkbox"/> Only one plant <input type="checkbox"/> All similar plants																															
Irrigation Delivery <table style="width: 100%;"> <tr> <td style="width: 33%;"><u>System:</u></td> <td style="width: 33%;"><u>Application Process:</u></td> <td style="width: 33%;"><u>Frequency</u></td> <td style="width: 33%;"><u>Water Source:</u></td> </tr> <tr> <td><input type="checkbox"/> Hand water</td> <td><input type="checkbox"/> Overhead broadcast</td> <td>_____ times/week for _____ min</td> <td><input type="checkbox"/> City Water-treated</td> </tr> <tr> <td><input type="checkbox"/> Sprinkler-(Manual Set)</td> <td><input type="checkbox"/> Per-plant emitter</td> <td><input type="checkbox"/> As needed (check soil only)</td> <td><input type="checkbox"/> Private Well</td> </tr> <tr> <td><input type="checkbox"/> Permanent Set sprinkler system</td> <td><input type="checkbox"/> Watered w/ lawn</td> <td><input type="checkbox"/> As needed (check weather only)</td> <td></td> </tr> <tr> <td><input type="checkbox"/> Drip/soaker hose</td> <td><input type="checkbox"/> Directly at base of plant</td> <td></td> <td></td> </tr> <tr> <td><input type="checkbox"/> Rill Flood</td> <td><input type="checkbox"/> At drip line</td> <td></td> <td></td> </tr> </table>								<u>System:</u>	<u>Application Process:</u>	<u>Frequency</u>	<u>Water Source:</u>	<input type="checkbox"/> Hand water	<input type="checkbox"/> Overhead broadcast	_____ times/week for _____ min	<input type="checkbox"/> City Water-treated	<input type="checkbox"/> Sprinkler-(Manual Set)	<input type="checkbox"/> Per-plant emitter	<input type="checkbox"/> As needed (check soil only)	<input type="checkbox"/> Private Well	<input type="checkbox"/> Permanent Set sprinkler system	<input type="checkbox"/> Watered w/ lawn	<input type="checkbox"/> As needed (check weather only)		<input type="checkbox"/> Drip/soaker hose	<input type="checkbox"/> Directly at base of plant			<input type="checkbox"/> Rill Flood	<input type="checkbox"/> At drip line		
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Has client applied fertilizer, insecticides, fungicides to this or nearby plants in the last 12-18 months?:			
<input type="checkbox"/> No <input type="checkbox"/> Yes, complete details		Date: _____ Product Name: _____	
		Rate: _____ Frequency: _____	
		How Applied: _____ Frequency: _____	
Has client used any of the following in the last two years? When and where and how?			
<input type="checkbox"/> Weed 'n Feed-type lawn products (selective herbicides)		<input type="checkbox"/> Roundup, Kleen-up, Knockout (non selective herbicides)	
<input type="checkbox"/> Triox, Noxall, Spike, or other (soil sterilant)		<input type="checkbox"/> Casoron, Preen (pre-emergent treatment)	
<input type="checkbox"/> Other: _____		When: _____	
Where: _____		How: _____	
Have any of the following happened near your affected plant or within your yard/garden in the past 3-5 years?			
<input type="checkbox"/> Construction/heavy equipment movement		<input type="checkbox"/> Change of soil grade (landscaping, pool, etc)	
<input type="checkbox"/> Addition of soil, organic matter or soil additives		<input type="checkbox"/> Soil disturbance, root injury	
<input type="checkbox"/> Driveway/roadway paving nearby		<input type="checkbox"/> Trunk/bark injury	
<input type="checkbox"/> Extreme drought (no irrigation for several months; spring/summer/fall)			
Illustrate or describe the problem. Include pattern of damage.			
Has this plant ever had this problem before? When?		When did you first notice the current problem?	
<input type="checkbox"/> Yes Date: ____/____/____		Approximate date: ____/____/____	
<input type="checkbox"/> No		<input type="checkbox"/> Developed very quickly <input type="checkbox"/> Is getting worse	
		<input type="checkbox"/> Developed gradually <input type="checkbox"/> Is not getting worse	
Diagnostic Resources:			
<input type="checkbox"/> Hortsense Pestsense <input type="checkbox"/> PICOL		<input type="checkbox"/> PNW Insect Weed Plant Disease	
<input type="checkbox"/> www._____.org/edu		<input type="checkbox"/> Other: _____	
Diagnosis/Recommendation:			
		Diagnosed by: _____	
		Delivered by: Circle one	
Handout provided? Yes or No Describe: _____		Code: _____ Phone E-mail In person	