Clearing Ama Quiz
Agni + Ama Cleanse Readiness Assessment

For each item, rate how often or much you **currently** feel, experience, intake, or do this item. To complete this form electronically, mark an X where applicable. "Adobe Fill & Sign" is a great (free) app for this.

1 = never/rarely
5 = sometimes
10 = often/always

For example:
Frozen Food: 1------X---------- 10
If you eat frozen fruit smoothie or ice-cold juice every morning, but use fresh ingredients for lunch and dinner, mark an "X" at about 3, or ⅓ of your weekly food intake.

Hungry at same times daily
1----------10
Hungry for same amount daily
1----------10
Energy level right after eating
1----------10
Feeling thirsty after eating
1----------10
Energy level 3-4 hours after eating
1----------10
Bowel Movement is uniform size/shape/color/consistency
1----------10
Bowel Movement has undigested particles
1----------10
Bowel Movement sinks (1) or floats (10)
1----------10
Bowel Movement sticky (1) or smooth (10)
1----------10
Urine is cloudy (1) or clear (10)
1----------10
Feeling lethargy and sluggishness
1----------10
Feeling heaviness in the body
1----------10
Feeling "brain fog" or unclear thinking
1----------10
Level of body odor (BM, urine, breath, armpits, feet)
1----------10
White coating on tongue (1=none, 10=full)
1----------10
How hungry do you feel in the morning, about an hour after waking?
1----------10
Does a strong taste ever stay in your mouth (i.e. metallic, sour)?
1----------10
Level of gassiness
1----------10
Number of food allergies and sensitivities
1----------10
Do you experience an inability to digest foods?
1----------10
Do you experience vomiting?
1----------10
Difficulty breathing after eating?
1----------10
Coughing after eating?
1----------10
For each item, rate how often or much you **currently** feel, experience, intake, or do this item.

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Do you feel weak even after eating enough food?
1----------10
How often do you have constipation?
1----------10
How often do you have loose stool?
1----------10
Do you have excess saliva in the mouth?
1----------10
How much do you sweat?
1----------10
Bloating
1----------10
Gurgling in abdomen
1----------10
Pain in abdomen before or after eating
1----------10
How often do you eat the following?
Leftovers
1----------10
Frozen Foods
1----------10
Dried Foods
1----------10
Fried Foods
1----------10
Packaged Foods
1----------10
Spicy Foods
1----------10
Warm Foods
1----------10
Liquid Foods
1----------10
Freshly Prepared Foods
1----------10
Seasonal Foods
1----------10
Spices and Seasonings
1----------10
Water I drink is cold (1) or hot (10)
1----------10
Level of inorganic chemical (man-made) content in each of the following?
Your home cleaning products
1----------10
Shampoo + Conditioner
1----------10
Soaps (Bath, Laundry, Dish, Dishwasher)
1----------10
Cosmetics
1----------10
Body Lotion
1----------10
Clothes
1----------10
Mattress
1----------10
Quality of your sleep?
1----------10
Quality of thoughts (1=negative, 10=positive):
1----------10
Quality of emotions (1=negative, 10=positive):
1----------10
Ability to embrace the unexpected?
1----------10
Sensitivity to strong sense inputs, i.e. sounds/light/smells/tastes/touches
1----------10
What is your normal body temperature?

_____
What is your normal resting pulse rate?

_____
>> **Send completed form to email below to receive your toxin level and where to begin your cleanse**<<

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