Privacy Policy

Nicky Porter Therapies

In the therapy setting, at the start of any client/therapist relationship, there is a certain amount of data collection that takes place in order for the therapist to ascertain a suitable treatment plan for their client.

It is explained to clients on their first visit that all information provided is confidential, that we abide by client confidentiality practices and that they are welcome to view their notes any time they should wish to.

Information held:

Client personal information:

- Name
- Address
- DOB
- Tel number
- Email address - clients are asked permission to be added to newsletter database.
- Occupation
- GP name and practice
- Emergency Contact - name and phone number

Client Medical history:

- Pre-existing medical conditions - explanations if yes
- Operations in previous 2 years
- Medications? - if yes, list
- Are they pregnant?
- Do they have any allergies - if yes, what are they?
- Are they receiving any other treatment? - if yes, what?
- Do they have any current injuries? - if yes, what, how did it happen and when?

Client lifestyle questions:

- Smoke? How many?
- Drink alcohol? How much?
- Drink water? How much?
- Special diet? if yes, details.
- Ask client to describe their stress levels - high/medium/low
- Ask client to describe their energy levels - high/medium/low
- Sleep patterns - good/average/poor
- Regular exercise? If yes, what and how often.
- Hobbies or time set aside for relaxation.
- Have they had massage/Reiki/hypnotherapy before? If yes, what for, how often, was it successful?

All the data is collected directly from the client during their first consultation and written onto a consultation record form. We then use this as a basis for discussion about their treatment plan, with more notes being taken to build up the picture of why they have attended a treatment session, their aims for the session and what outcome they hope to achieve at the end of the treatment plan.

This information is hand written and stored in individual folders, in a locked filing cabinet in the main treatment room. I am the only person with access to the filing cabinet and the notes never leave the premises.

Sharing of data

The only times data will be shared is with written consent from the client. If another professional (e.g. GP, physio, solicitor) has requested copies of the written records, these will be provided in the form of scanned .pdf documents as long as written consent has been obtained.

The only exception to this rule is if I consider the client to be a danger to themselves or to others when the authorities, or relevant medical professionals will be alerted.

Retention/deletion of data

Under normal circumstances, data will be securely kept for a period of seven years. In the case of lapsed clients, this will then be destroyed following a seven year period of absence.

If a client requests that their records be deleted/destroyed this will take place as soon as possible.